Mid and South Essex Health and Care Partnership

Report of the Clinical Senate Independent Review of Community Inpatient Beds held on 04 and 06 April 2022

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Glossary of abbreviations used in the report

AHP	Allied Health Professional
CCG	Clinical Commissioning Group
EPUT	Essex Partnership University NHS Foundation Trust
ESD	Early Supported Discharge
FREDA	Frailty, End of Live & Dementia Assessment
HASU	Hyper-Acute Stroke Unit
ICS	Integrated Care System
ICSS	Integrated Community Stroke Service
IT	Information Technology
MDT	Multi-Disciplinary Team
MSE	Mid and South Essex Health and Care Partnership
NELFT	North East London NHS Foundation Trust
PCN	Primary Care Networks
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
SSNAP	Sentinel Stroke National Audit Programme

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Foreword from Clinical Senate Chair

The Clinical Senate was delighted to support Mid and South Essex Health and Care Partnership by providing independent clinical advice on their proposals for the future configuration of community inpatient beds resulting from the urgent service changes made in response to the COVID-19 pandemic.

The Clinical Senate was very pleased to support the MSE team once again by arranging an accelerated review process to mitigate the delay caused by the COVID-19 related suspension of the Clinical Senate's activities by the NHS England and NHS Improvement East of England Regional Executive and meet MSE's timeline for system-wide consultation. A Panel was therefore convened at short notice and met over three evenings, resulting in nine recommendations for MSE to consider.

I would like to thank the MSE team for providing such clear and comprehensive information and attending the final session to respond to questions in such an open and honest way. I would also like to thank Dr Hazel Stuart for Chairing the Pre-Panel meeting and all the panel members for asking searching questions and contributing with their wide and varied expertise and, of course, for giving up their personal time.

We wish the MSE teams well with their ongoing work and very much hope we can assist them again in the future.

Dr Bernard Brett

East of England Clinical Senate Chair and Clinical Review Panel Chair

1. Executive Summary

The East of England Clinical Senate provided an independent clinical panel review of the proposal for the Mid and South Essex Health and Care Partnership's (MSE) future configuration of community inpatient beds.

The panel were asked to review the proposals, focusing on specific questions asked by MSE. The panel has responded to each of these questions and has made a number of recommendations for the MSE team.

The specific questions asked, and the Panel's response are:

1. **Overall: Are the emerging options for the future configuration of community inpatient beds likely to result in good patient outcomes and support the flow of patients through the system's beds?**

   The Panel felt that the emerging options had the potential to deliver good patient outcomes and support patient flow.

2. **Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?**

   The Panel supported the clinical model.

3. **Stroke: Is the proposed introduction of dedicated, ring fenced stroke rehabilitation beds in the community aligned with the current evidence base and likely to improve patient outcomes?**

   The Panel supported the introduction of dedicated, ring-fenced stroke rehabilitation beds to deliver more consistent and resilient care.

4. Sub-acute frailty: Is the model that has been developed clinically sound and likely to result in at least comparable outcomes for frail older people, and how might it be further developed over time?

The Panel felt that many elements of the sub-acute frailty pathways were very positive. Moving forward the Panel felt that more could be done to build on the Recovery at Home pilot.

The Panel have made several recommendations of focus to the MSE team from this review. These are:

- **Recommendation 1:** Optimisation of the Stroke pathway
- **Recommendation 2:** Digital solutions
    - **Recommendation 2.1:** Digital pathway communications
    - **Recommendation 2.2:** Digital virtual ward
    - **Recommendation 2.3:** Digital development for families and carers
- **Recommendation 3:** The development of a comprehensive Workforce Strategy.
- **Recommendation 4:** Focus on ensuring system leadership is enhanced at all levels.
- **Recommendation 5:** Further focus on pathway transformation using learning from the Recovery at Home pathway.
- **Recommendation 6:** Outcomes – to accelerate the approach to using outcomes-based tools.
- **Recommendation 7:** A continued focus on access with co-production.
- **Recommendation 8:** Further development of the Bed Bureau function with enhanced clinical input, facilitating more of the pull model and oversight of whole pathways of care.
- **Recommendation 9:** The Panel were very impressed with much of the work around frailty and stroke but felt there would be significant benefit in increasing the level of social care involvement.

The areas of the recommendations above should be read in the context of the broader findings of the clinical review panel as laid out in the Key Findings (Section 4) of this report.

2. Introduction

The challenge presented by COVID-19 led to the urgent reconfiguration of community inpatient beds across mid and south Essex. This included consolidating the provision of intermediate care beds on to a smaller number of sites, establishing a Recovery at Home pilot and relocating two hospital acute frailty wards from a main acute unit to a community hospital. Rather than simply reverting to the 'as was' configuration, which had a range of shortcomings, MSE have in recent months been developing options for the future number, role and location of their community beds, including how to make better use of these assets to support choice, personalisation and patient experience. The plan is to consult the public on these options in 2022.

MSE have approached the Clinical Senate to provide an independent clinical review of the proposals focusing on the future configuration of community inpatient beds. The programme is focused on community beds and has three distinct strands:

- Intermediate care: beds which are primarily used to enable older people to be discharged from a main acute hospital for a short period of personalised, goal-based rehabilitation, when they are not yet well enough to return to their usual place of residence,

- Stroke rehabilitation beds: those patients who have had a stroke and will benefit from a period of focused rehabilitation in a dedicated facility and

- Sub-acute frailty: a sub-set of frail patients that have been admitted to Basildon Hospital who will benefit from being transferred to a sub-acute medical setting.

As well as looking at each of these service areas and pathways separately, MSE are considering the key role that these beds collectively play at a system-level in enabling the smooth and appropriate 'flow' of patients through the MSE acute hospitals; in helping to meet emergency demand, especially during winter (and COVID-19) peaks; and in supporting the MSE elective recovery programme.

3. Methodology and Governance

3.1 Clinical review panel members (Appendix 2) from within and outside of the East of England and patient representatives (experts by experience) were identified by their clinical expertise and background and invited to join the review panel. All panel members signed conflict of interest and confidentiality declarations (Appendix 3).

3.2 Terms of Reference for the review were agreed between Dr Bernard Brett, Chair of East of England Clinical Senate and James Wilson, Transformation Director, Mid and South Essex Health and Care Partnership (Appendix 1).

3.3 The evidence received on 22 March 2022 was discussed at the pre-panel teleconference on 29 March 2022, chaired by Dr Hazel Stuart in the absence of Dr Bernard Brett, to prepare panel members and discuss potential key lines of enquiry.

3.4 Two clinical review panels took place on 04 April and 06 April 2022. The MSE team attended on 06 April 2022 to respond to questions raised by the panel on 04 April 2022 and provide further supporting and contextual detail. The proposals were discussed with the panel in more detail.

3.5 Sections of the draft report were sent to the clinical review panel members for review and confirmation of accuracy and to the MSE team for review for points of accuracy on 05 May 2022.

3.6 The final draft of the report was submitted to the East of England Clinical Senate Council on 27 June 2022. Senate Council agreed that the clinical review panel had fulfilled the Terms of Reference for the review and confirmed the report.

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

4. Summary of Key Findings:

4.1 The Panel thanked the MSE team for the information and engagement with the Panel, their open and honest approach, as well as the willingness of the MSE team to answer the questions from the Panel.

4.2 The Panel were very positive towards the MSE team seeking advice and engagement with the Clinical Senate.

4.3 Following the submission of evidence and additionally the presentation session to the Panel, including discussion between the MSE team and the Panel in the form of question and answers, the Panel have developed this report which includes the key findings of the Panel as well as recommendations for consideration by the sponsoring organisation.

4.4 **Stroke pathway**: **Please refer to Recommendation 1**

The Panel recognised much work had already been undertaken but felt there needed to be a continued focus on optimising the stroke pathway with an aim to minimise the number of patient moves where possible, and ensure that the appropriate criteria and assessments are in place to deliver the correct pathway for each patient. The Panel felt further work was also needed to ensure there were clear criteria for all the possible pathways.

Concentrating stroke rehabilitation services on two sites would provide more resilience than the previous model but still could be challenging in terms of

staffing. The Panel felt that the two rehabilitation units should work together as much as possible to share staffing resource and build in resilience.

On 28 February 2022, a national service model for an Integrated Community Stroke Service (ICSS) was published by the NHS[1]. The ICSS is part of the National Stroke Service model and is an integrated seven days per week service, providing early supported discharge, high-intensive and needs-based community stroke rehabilitation and disability management.

The Panel explored the components of the ICSS model with the MSE team. The MSE team advised that the Early Supported Discharge (ESD) team supports discharge from the acute stroke unit as well as receiving patients who have been an in-patient, so already follows the new ICSS model. The referral process is through a well-established joint care pathway document that accompanies the patient in paper form, as well as being held in an electronic shared drive. The MSE team presented that having a shared document that can be inputted by the acute and ESD teams works well and has brought a sense of trust between the teams.

The proposed model with ring-fenced beds will fit well with the ICSS model, will have clarity in terms of pathways and the standards will continue to be monitored by the Sentinel Stroke National Audit Programme (SSNAP) as currently.

The Panel also discussed with MSE the future modelling around the Hyper Acute Stroke Unit (HASU) as this is an important part of the stroke pathway. It was noted that patients could move at least three times after initial hospital contact (to Acute Trust for initial assessment and treatment, to the HASU when established, back to the original Trust for post HASU care and then to community rehabilitation). The suggested changes in community provision will not negatively impact on this. It

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[1] NHS England (2022) National service model for an integrated community stroke service https://www.england.nhs.uk/publication/national-service-model-for-an-integrated-community-stroke-service/ accessed 21.02.2022

was also noted that post-acute care could include the ESD service, community rehabilitation, local Trust rehabilitation or rehabilitation at home. MSE explained that this is an area where senior clinical input and decision making is required.

The Panel wished to understand more about the inclusion and exclusion criteria for these community beds. MSE informed the Panel that the short-term plan is for a Level 3 rehabilitation service. However, when considering the level of physician input and upskilling of therapists and nurses to take on senior leadership roles, there could be potential to develop some in-house level 2b rehabilitation provision, at least while patients wait for tertiary units, but this is not the plan for the short term.

4.5 Digital: Please refer to Recommendation 2.1, 2.2 and 2.3.

The Panel recognised that significant work had already been undertaken in considering digital solutions throughout patient pathways and to facilitate transformation of patient pathways. The widespread use of a single system (SystmOne) amongst primary care and community providers with enabled access for other providers such as the Out of Hours service and the Hospice service was a very positive step. However, it seems that this does not currently provide seamless communication so referral forms are used to provide relevant clinical and social care information. It was noted that the ability to access an electronic system does not mean this is necessarily routine practice if this is not the primary system a clinician uses. The Panel felt there was a need to continue to work towards enhanced digital information sharing across clinical pathways**.**

The Panel heard that MSE had gained experience in the use of virtual wards during the COVID-19 pandemic and in specialities such as frailty, respiratory and end of life care, with roll out planned in cardiology soon. The development of virtual wards is on-going and is being considered in service design, bed capacity and configuration. The Panel were also informed that not all the existing estate is set up for digital enablement.

The Panel noted that other technology such as virtual monitoring may also enable more patients to be cared for through the Recovery at Home pathway.

The proper set-up and use of virtual wards, where appropriate, should be increased to enable more rehabilitation at home. The experience already gained in response to the COVID-19 pandemic and for patients with respiratory problems should be built on further.

Digital solutions may also offer part of the solution to family and carer access challenges, but this should not be instead of Recommendation 7 regarding transport access. Co-produced digital solutions are more likely to produce positive end results for the MSE team.

4.6 Workforce: Please refer to Recommendation 3

There are national shortages of staff from many professions involved in delivering rehabilitation services. The Panel concluded that it will be a challenge to maintain appropriate staffing levels with the required competencies in all areas, for example stroke rehabilitation is planned to take place on two community hospital sites and on an outpatient basis. The Panel questioned whether there was more that could be implemented around building shared competencies with staff working in the social care sector. The Panel were impressed with the training already developed to deliver competency training in end-of-life care, personalised care and frailty assessment, but were not sufficiently assured that MSE have the required capacity to truly deliver this ambitious system-wide training.

4.7 System leadership focus at all levels: Please refer to Recommendation 4

The Panel were advised that clinical leadership is at the heart of the MSE ICS with a system of Stewardship being used. Stewardship is about bringing together front-line staff and managers within a care area to improve quality and make better use of resources. It consists of a values-based approach which the clinical leadership team believe assists in embedding skills. Ageing Well and stroke care are included within this programme as are frailty, end of life care, anticipatory care and personalisation across the MSE ICS system.

There is a clinical leadership competencies training package which has strong clinical oversight from various clinical leaders to support teams working directly

with patients. The Panel heard that there is an ambitious learning and education programme across MSE to embed this training programme which is planned to commence in May 2022, with a series of workshops sharing the culture change towards shared decision making. A learning academy platform is being built so that all tiers of staff can engage in the training. This includes the development of assessment tools for all professions to ensure a consistent approach. It is planned that this will be an on-going programme of work to support the change.

The Panel felt there should be a focus on ensuring that system leadership is enhanced at all levels. Although there is evidence of strong system-level leadership and impressive plans in place for consistent training, the Panel considers that there is an ongoing need to continue to work to ensure leadership at the shop floor level is also strong and consistent (although MSE may be ahead of many other systems in their planning). The Panel advised that MSE should ensure that AHP and nursing leadership is enhanced to enable empowered decision making on the ground. Leadership development should also be designed to help deliver cultural change.

4.8 Pathway transformation: Please refer to Recommendation 5

The Panel felt that the Recovery at Home pilot in the Halstead area seemed to have been very successful and the Panel were impressed with this work. The Panel feel that even more focus on learning from this pilot should be taken into account with consideration for pathway changes throughout the MSE system and potentially reconsideration of the number of beds required in the longer term.

4.9 Outcomes: Please refer to Recommendation 6

Whilst the Panel were impressed with the Patient Reported Outcome Measures (PROMs) tool used for the Recovery at Home service, including the element looking at patient and carer goals, and the plans to standardise this type of approach throughout the MSE system, the Panel felt this key patient-focused work could be further accelerated

The Panel heard the MSE clinical team describe an Ageing Well dashboard which is being developed. This dashboard will include both “business as usual”

indicators as well as additional indicators that traditionally were not previously measured across the bed base and the Recovery at Home pathways. These include patients' personalisation in their own goals, goal attainment measures and whether patients' desired goals are reached, as well as health related quality of life indicators. Through the development and embedding of this dashboard, each service will be able to see the difference that they are making beyond the use of traditional activity measures. This is considered critical in the Ageing Well dashboard.

The MSE clinical team described the use of some of the tools they are using to help build this dashboard such as the Frailty, End of Life and Dementia Assessment (FREDA) tool and the Comprehensive Geriatric Assessment toolkit to evidence delivery of high impact and high evidence interventions that are known to improve outcomes in frailty. Use has been made of learning from the Recovery at Home pilot and it is envisaged the dashboard will also be rolled out across the community bed base. This includes use of consistent code capture so that there is evidence of what is actually happening. All providers will use the same tool as it is being rolled out across the ICS as a whole system approach, including Primary Care Network and Integrated Neighbourhood models.

4.10 Access: Please refer to Recommendation 7

The Panel were informed that patient, family and carer access to the community sites, is recognised as a key part of the proposal. Direct patient, family and carer access to the sites has been studied. Additionally, the Panel were presented with documentation demonstrating travel times. However, the MSE team are also planning to conduct an Integrated Impact Assessment, which is complex, but will include public transport access for family and carers.

Access, particularly for those using public transport, is likely to be a challenge for many families and carers. The location of community beds is, understandably, based on the current estate rather than necessarily the ideal locations for facilitating access (the Panel recognised that there are constraints on capital resources). Within the recommendations the Panel consider that co-produced

solutions are important, by engaging with local transport services, councils and the voluntary sector, as well as patients and carers**.**

4.11 Bed Bureau: Please refer to Recommendation 8

The Panel sought to understand the clinical leadership of the existing Bed Bureau and its decision making. The Panel were informed that the Bed Bureau is a capacity tool that is an administrative function that can draw on clinical input as required. The MSE team acknowledged that this is an area where they are reviewing the vision and plans for the long-term Discharge to Assess and Transfer of Care models. The MSE team advised that this is part of a wider aspect to be reviewed within patient flow work and improvement, looking to achieve consistency in transfer of care from the acute hospitals.

The Panel agreed that a single point to coordinate the access to, and use of, community rehabilitation services made sense. They agreed that this could be enhanced further with a multidisciplinary clinical and social care team which is part of the existing Discharge to Assess plans across MSE. This would also give an opportunity for quality improvement activity including increased capability to shape pathways for the future. The Panel heard about the desire to move to more of a pull rather than push model but did not feel that this particularly came across in the descriptions of the pathways so far. The Panel felt that enhanced clinical input could also help move the Bed Bureau into more of a pathway coordination team.

4.12 Social Care: Please refer to Recommendation 9

The Panel were impressed with much of the work around frailty and stroke but felt that although there were regular meetings with the Director of Adult Social Services and with their commissioning teams, there seemed to be less social care participation and input in the development of the MSE plans as they were presented than would ideally be the case. The Panel felt it was very important to ensure that social care is fully incorporated into future planning and development, thinking about the context of the whole person, which includes family and carers.

4.13 Engagement and implementation of findings

The Panel were impressed with the degree of engagement, despite the COVID-19 pandemic which had clearly made this challenging. The Panel were informed that there is an external company working with the MSE team on the development of a report.

There has been pre-consultation engagement directly with patients; with existing staff teams; and focus groups with public and external stakeholders. Emerging themes shared with the Panel include participation of family, not just with visiting but involvement in care plans post discharge, including training and up-skilling family members. From patients there had been feedback regarding the need for good discharge planning; clear communication both within and across professionals, and also with families and patients at every point in their care journey; and personalisation in recognising that everyone's circumstances are different.

The Panel were made aware that during consultation MSE are keen to work with families, carers and friends to determine how to improve and develop direct engagement with patient care where required. The consultation will explore whether there are opportunities (if appropriate) to deliver training, for example on wound care and medication.

The Panel suggest that MSE must carefully consider the key messages being collected through the engagement process and deliver on them.

4.14 Health Inequalities

The Panel heard that work on Health Inequalities is in progress and will be taken further forward. Across the ICS, Health Inequalities are one of the agreed priorities. Recently the MSE team have started using an Integrated Impact Assessment in which inequalities features as a central element.

4.15 Governance

The Panel wanted to understand the governance and responsibility around the multiple pathways involving multiple providers. The MSE team advised that their

system is inherently complex in that there are three separate community providers and one acute provider operating across three sites. The community providers now work under one Community Collaborative, which brings together three sovereign organisations and so in terms of clinical leadership and clinical governance this does rest with each of these organisations. However, in the programme for this proposal, the clinical leadership is as discussed in the Clinical Leadership part of this report (please refer to 4.7 above). The ICS has an accountable Medical Director.

With the sub-acute frailty wards the clinical governance and leadership is the responsibility of the geriatric medicine staff from the Basildon Hospital site.

The MSE team explained to the Panel that across the three parts of the Community Collaborative, there are different arrangements. Essex Partnership University NHS Foundation Trust (EPUT) run Mountnessing Court and Cumberlege; North East London NHS Foundation Trust (NELFT) run the intermediate care beds at Brentwood and Mayfield; Provide CIC run St Peter's and Halstead; and Basildon Hospital run the two sub-acute wards on the Brentwood site.

The Panel heard that transfer of care to primary care, in terms of discharge planning, is made easier because all of primary care use SystmOne.

For stroke rehabilitation, the MSE team informed the Panel that there is a well-established nurse led model which will continue to be built upon for the future.

4.16 Estate

The Panel heard that the plan to develop the beds in the south geography of the MSE system is a legacy of where the estate has been historically located and is not fully aligned with population density or need. There are capital restraints around making significant changes to the estate. The population density is also greater in the south of the system.

4.17 Sub-acute frailty – acute, deteriorating patient

The Panel were reassured to hear about the seven-day consultant presence on ward sites, out of hours medical presence, equipment and diagnostic provision. The MSE team explained that patients who are transferred to the sub-acute frailty wards are carefully selected by the geriatric medicine staff, identifying those patients who are least likely to require other speciality input. If the patients are felt to require further specialist input, then they are not considered for transfer from the acute hospital to the community hospitals

The Panel were informed that very few of the patients transferred to the community hospitals had required transfer back to the acute hospital for treatment of an acute deterioration or for other clinical reasons. The Panel do however feel that MSE need to give consideration to the triggers for transfer and clarity of provision for the transfer to the acute site, of any clinically deteriorating patients and the management of urgent situations.

4.18 Voluntary sector

The Panel heard about how the voluntary sector links in with all of the community beds. There is recognition by the MSE team that now that we are coming out of the COVID-19 pandemic that there is potential to revisit the opportunities for strengthening links with the voluntary sector.

4.19 Additional comment noted at Clinical Council meeting on 27 June 2022

The Clinical Senate Council noted the beds were ringfenced for stroke use only and broader neurological rehabilitation may need more attention. It was suggested for MSE to have a Quality Impact Assessment for general rehabilitation that would add to the further development of rehabilitation services.

5. Conclusions:

The Panel felt there was a clinical basis to support the proposal. The location of the beds, constrained by the current estate, could however impact on the access for patients' families, carers and friends. The relocation of the frailty wards will have benefits to acute hospital capacity and therefore potentially to patient flow. The Panel were reassured that the same consultants who selected suitable patients for transfer to the community hospitals were also the consultants who continued to be responsible for patient care on the frailty unit.

The Recovery at Home pilot in the Halstead area appears to have been very successful and the Panel were particularly impressed with the PROMs tool used with a focus on patient and carer goals. Further learning from the pilot and incorporating this learning in pathway development, is featured within the recommendations.

The key questions the Clinical Senate were asked to address in this review and the response of the Panel are as follows.

1. **Overall: Are the emerging options for the future configuration of community inpatient beds likely to result in good patient outcomes and support the flow of patients through the system's beds?**
   In answer to question one: The Panel felt that the emerging options had the potential to deliver good patient outcomes and support patient flow, although the MSE team are advised to take account of the recommendations to help ensure that this is delivered.

2. **Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?**
   In response to the second question: The clinical model, aimed at trying to help patients return to their previous level of functioning, was supported, along with the plans to enhance staff training to support understanding of personalised care, frailty assessment and end of life care. The locations of

the community beds are constrained by the location of the current system-wide viable estate. If the potential access issues for family and carers are addressed and the Panel's recommendations are taken into account, then improvement in patient outcomes should be achieved.

3. **Stroke: Is the proposed introduction of dedicated, ring fenced stroke rehabilitation beds in the community aligned with the current evidence base and likely to improve patient outcomes?**

   In response to the third question: The Panel fully supported the introduction of dedicated, ring-fenced stroke rehabilitation beds. This is likely to help deliver more consistent and more resilient care. Two sites will deliver a better solution in terms of access than one, but the Panel felt that this could still prove to be a challenge in terms of maintaining appropriate staffing levels. The Panel felt that cross site working may be required for several staff groups. Please refer to the Recommendations.

4. **Sub-acute frailty: Is the model that has been developed clinically sound and likely to result in at least comparable outcomes for frail older people, and how might it be further developed over time?**

   In response to the fourth question: The Panel felt that many elements of the sub-acute frailty pathways were very positive. These include the enhanced staff training to help assess frailty more consistently, the dedicated inpatient area for the care of patients suffering from frailty and the single team making many of the initial assessments and then being responsible for delivering rehabilitation.

Moving forward, the Panel felt that more could be done to build on the Recovery at Home pilot. This includes the use of virtual technology, new ways of working and enhanced liaison with the voluntary sector which may enable more patients with frailty to avoid inpatient stays altogether. Please refer to the Recommendations.

6. Recommendations:

Recommendation 1

Optimisation of the Stroke pathway.

The Panel recommends further co-produced work be undertaken to optimise the Stroke pathway.

The Panel recognised much work had already been undertaken but felt there needed to be a continued focus on optimising the stroke pathway with an aim to minimise the number of patient moves in the overall stroke pathway where possible, and ensure that the appropriate criteria and assessments are in place to deliver the correct pathway for each patient. It was noted that patients could move at least three times after initial hospital contact. The Panel felt further work was also needed to ensure there were clear criteria for all the possible pathways.

Concentrating stroke rehabilitation services on two sites would provide more resilience than the previous model but still could be challenging in terms of staffing. The Panel felt that the two rehabilitation units should work together as much as possible to share staffing resource and build in resilience.

Recommendation 2.1

Digital pathway communications.

The Panel recommends that MSE ensure that digital solutions enable seamless communication throughout patient pathways and facilitate transformation of patient pathways.

Recommendation 2.2

Digital virtual ward.

The Panel recommends that MSE further develop the use of virtual wards and virtual monitoring to enable more rehabilitation at home.

Recommendation 2.3

Digital development for families and carers.

The Panel recommends that co-designed digital solutions should be developed to address family and carer in-person visiting and challenges.

Recommendation 3

The development of a comprehensive Workforce Strategy.

The Panel recommends the development of a comprehensive Workforce Strategy with ongoing focus on new ways of working, new roles, and competency sign-off, as well as recruitment and retention.

Recommendation 4

Focus on ensuring system leadership is enhanced at all levels.

The Panel recommends that there should be a focus on ensuring that system leadership is enhanced at all levels.

Recommendation 5

Further focus on Pathway transformation using learning from the Recovery at Home pathway.

The Panel recommends that even more focus on learning from the Recovery at Home pilot is taken into account with consideration for co-produced pathway changes throughout the MSE system and potentially reconsideration of the number of beds required.

Recommendation 6

Outcomes - to accelerate the approach to using outcomes-based tools.

The Panel recommends that the plans to standardise the use of outcomes-based tools, which include patient and carer goals, should be accelerated throughout the MSE system.

Recommendation 7

A continued focus on access with co-production.

The Panel recommends that co-produced solutions should be developed by engaging with local transport services; councils; the voluntary sector; and patients, families and carers.

Recommendation 8

Further development of the Bed Bureau function with enhanced clinical input, facilitating more of the pull model and oversight of whole pathways of care.

The Panel recommends that enhanced clinical input could be provided into the Bed Bureau to move it to more of a pathway coordination team.

Recommendation 9

The Panel were very impressed with much of the work around frailty and stroke but felt there would be significant benefit in increasing the level of social care involvement.

The Panel recommends increasing the level of social care involvement in the developing plans.

APPENDIX 1: Terms of Reference for the Review

NHS
East of England
Clinical Senate

East of England Clinical Senate

Independent Clinical Review of Mid and South Essex Community Inpatient Beds

04 and 06 April 2022

Terms of Reference agreed by:

Commissioning organisation: **Mid & South Essex Health and Care Partnership**

Responsible / lead officer:

James Wilson, Transformation Director, Essex Partnership University NHSFT, Provide, North East London NHSFT

Community Inpatient Beds Programme Senior Responsible Officer

Signature 

Panel chair:

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

Signature

Date: 22 March 2022

Supporting / background information for the clinical review for completion by commissioning organisation.	
When is the advice required by? Please provide any critical dates	The advice is required to feed into the Pre-Consultation Business Case (PCBC), which will be considered by the Joint Committee of the five Clinical Commissioning Groups. This is being developed during March and April 2022, so a draft report, including recommendations, is requested by mid-April. This will enable the key findings, recommendations and system's draft responses to be incorporated.
What is the name of the body / organisation commissioning the work?	Mid & South Essex Health and Care Partnership (to become Mid & South Essex Integrated Care System on 1 July 2022, subject to legislation).
How will the advice be used and by whom?	The advice will be used by the programme in several ways: • To further develop and finalise the proposed configuration of community beds for intermediate care, stroke rehabilitation and sub-acute frailty, prior to public consultation in summer 2022 • To feed into the PCBC • As part of the Stage 2 NHSE assurance process
What type of support is Senate being asked to provide: a) Assessment of clinical services b) Early advice to inform a clinical service model c) Review of proposed clinical model(s) (or follow up review from b above) d) Review of case for change, including the appraisal of the clinical evidence) e) Informal facilitation to enable further work f) Clinical reconfiguration or integration related to merger of trusts g) Advice on complex or (publicly) controversial proposals for service change h) Other?	The Senate is being asked to: • Consider the clarity of the case for change, noting that urgent changes (without consultation) were made to the community bed configuration in MSE as part of the system's response to Covid, and decisions now need to be taken on the future focus and location of these beds • Review the clinical models and evidence presented – focusing on the role of community inpatient beds within them – for the three key elements of the programme: intermediate care; inpatient stroke rehabilitation; and sub-acute frailty at Brentwood Hospital • Offer advice on how the proposals might be further developed or strengthened
Is the advice being requested from the Senate a) Informal early advice or a 'sense check' on developing proposals	The advice is being requested to inform Stage 2 of the NHS England assurance process, prior to planned public consultation in the summer of 2022

b) Early advice for Stage 1 of the NHS England Assurance process c) Formal clinical review to inform Stage 2 of the NHS England Assurance process and/ or your Consultation Business Case d) Other?	
Does the matter involve revisiting a strategic decision that has already been made? If so what, by whom and when?	Some elements of the proposed approach to stroke rehabilitation are relevant to a previous consultation (which focused on acute reconfiguration) held in 2017 ('your care in the best place'). This consultation was wide ranging, encompassing a number of acute specialties, one of which was stroke and the proposed establishment of a hyper-acute stroke unit (HASU) at Basildon Hospital. Further details of this consultation are included in the evidence submitted (overview and context section).
Is the matter subject to other advisory or scrutiny processes?	No

Aims and objectives of the clinical review

In 2020 as part of its response to Covid MSE made a number of urgent changes to the focus and location of its community inpatient beds. The key changes were:

- Consolidation of intermediate care beds from six sites to three
- The relocation of two frailty wards from the main Basildon Hospital site to Brentwood Community Hospital (~10 miles away), to enable critical care capacity at Basildon to be rapidly expanded
- The mobilisation of a recovery at home service for the Halstead area of Mid Essex

As these changes were urgent, it was not possible to engage or consult on them prior to their introduction.

As a result, in 2021 MSE began a programme to determine what the future focus, configuration and location of community beds should be. This will require public consultation, which is planned for the summer of 2022.

There are three main service areas affected by this work:

- Intermediate care beds, which in MSE focus on supporting patients who have been admitted to one of the three main acute hospital and who require a period of bedded recovery and rehabilitation before they can return home
- inpatient stroke rehabilitation beds, which have never previously been ring-fenced

- the sub-acute frailty beds (two wards), which are currently provided at the Brentwood Community Hospital site with care provided by the Basildon Hospital acute team.

Scope of the review

The scope of this review is the future number, focus and location of community inpatient beds across Mid & South Essex.

As outlined above, there are three main service areas that are within scope:

- Intermediate care beds
- Inpatient stroke rehabilitation beds
- Sub-acute frailty beds at Brentwood Community Hospital

Out of scope

Although the wider care models and pathways that the inpatient community beds form part of are clearly relevant to this review, they are not themselves within scope, and they will not be part of any future public consultation.

For example, although MSE's broader strategic approach to ageing well is set out in the evidence submitted - as this will help the Panel to determine the place of community inpatient beds with it - the Senate are not being asked to specifically comment on the overall approach. Rather, the focus is on the proposed number, focus and location of the beds themselves.

The same logic applies to the overall stroke pathway, which encompasses prevention right through to post-rehabilitation. This is described for context but the focus of the review is on the proposed ring-fenced inpatient stroke rehabilitation beds, including the number and location.

Purpose of the review

The Clinical Senate is being asked to review the available evidence, provide a desk top review and make appropriate recommendations to the programme from its findings.

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

1. **Overall: Are the emerging options for the future configuration of community inpatient beds likely to result in good patient outcomes and support the flow of patients through the system's beds?**
2. **Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?**

3. **Stroke: Is the proposed introduction of dedicated, ring fenced stroke rehabilitation beds in the community aligned with the current evidence base and likely to improve patient outcomes?**
4. **Sub-acute frailty: Is the model that has been developed clinically sound and likely to result in at least comparable outcomes for frail older people, and how might it be further developed over time?**

For info only – the following information is standard to all clinical review panel terms of reference:

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

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

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

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

- Is there a clear vision for the proposals, i.e. what is the intended aim?
- Are the expected outcomes and benefits of delivery for patients of this proposed model clear and are there clear plans for how it / they will be measured?
- Is there evidence of clinical leadership and engagement in the development of the options/ preferred model?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g. sustainability of cover, clinical expertise).
- Is there evidence that the proposed model will ensure equity in access to services for the population you serve, and how it could reduce inequalities in health?
- If there is a potential increase in travel times for some patients, is this outweighed by the clinical benefits?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals explain how the model be staffed? Is there appropriate information on recruitment, retention, availability and capability of staff and the sustainability of the workforce?

- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. the next ten years or more)?
- Do the proposals align with the local strategies and delivery plans (e.g. Sustainability and Transformation Plans / Integrated Care System plans and strategy)? Do they demonstrate alignment / integration of services (e.g. the link between primary care / social care / mental health services/ community services and acute provision including information systems)?
- Do the proposals demonstrate good alignment with national policy and planning guidance?
- Does the options appraisal consider a networked or Alliance approach - cooperation and collaboration with other sites and/or organisations?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?

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

Timeline:

The clinical review panel will be held on the 04 and 06 April 2022. A schedule of agreed key dates can be found at Appendix A.

Reporting arrangements:

The clinical review panel will provide a report to the Clinical Senate Council which will ensure the panel met the agreed Terms of Reference, agree the report and be accountable for the advice contained in the final report.

Methodology:

The most appropriate methodology for the review will be agreed with the commissioner of the review and Senate Council. There are a number of options, the most usual methodology will be a face to face clinical review panel, providing the commissioner of the proposals the opportunity to have a two-way discussion of the proposals with the review panel. In this case, the review will be undertaken by a combination of

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

Other approaches may include a desktop review, and short review by teleconference. Full methodology will be agreed in all cases.

Report of the clinical review:

A draft report will be made to the commissioning organisation for fact (points of accuracy) checking prior to publication.

Comments / correction must be received from the commissioning organisation within **six working days**.

The report will be submitted to a meeting of Clinical Senate Council on a date to be confirmed, but to fit in with the MSE next stage timelines, to ensure the review has met the agreed Terms of Reference and to agree the report.

The final report will be issued to the commissioning organisation following the Council Senate Council meeting. The commissioning organisation forthwith becomes the owner of the report.

Communication, media handling and Freedom of Information (Act) requests:

Communications in respect of the review will be managed by the commissioning organisation. The Clinical Senate will publish the report once the service change proposal has completed the full NHS England process, or at a time that is appropriate to the proposals. This will be agreed with the commissioning organisation.

The commissioning organisation, as the owner of the report and any evidence and or data provided for the review, will be responsible for handling any formal requests for information under the Freedom of Information Act 2000, irrespective of whether the request is received by either the Clinical Senate or commissioning organisation. (note: NHS Commissioning Board known as NHS England is the statutory body with responsibility for FOI requests received either directly or by the Clinical Senate and will be advised of all such requests received directly by the Clinical Senate and confirmation that the commissioning organisation will be responding to the request).

Confidentiality:

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

All clinical review panel members will be required to sign a Confidentiality Agreement and declare any interests, potential or otherwise.

The detail of any potential, or actual, conflict of interest will be discussed with the Panel Chair who will make a final decision on the participation of the Panel member. This may also be discussed with the commissioning organisation and agreement made between them and the Clinical Senate as to whether or not the member will join the review panel.

Resources:

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

The clinical review panel may request any additional existing documentary evidence from the commissioning organisation. Any requests will be appropriate to the review, reasonable and manageable. The review panel will not ask the commissioner of the review to provide new evidence or information that it does not currently hold.

Accountability and governance:

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

The East of England Clinical Senate is a non-statutory advisory body and will submit the report to the commissioning organisation, who will be the owners of the final report.

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

Functions, responsibilities and roles of the parties:

The **commissioning organisation** will

i. provide the Clinical Senate review panel with the clinical case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Is it recommended that the evidence supports the questions laid out above. The level of detail though will be appropriate and in proportion to the stage of development of the proposals. For NHS England Service Change Assurance process 'Stage 2' reviews, Clinical Senate provides supporting information on the evidence it would expect to see
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy
iii. undertake not to attempt to unduly influence any members of the clinical review panel during the review
iv. be responsible for responding to all Freedom of Information requests related to the review and proposals and
v. arrange and bear the cost of suitable accommodation (as advised by Clinical Senate support team) for the panel and panel members.

Clinical Senate Council and the commissioning organisation will

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

Clinical Senate Council will

i. appoint a clinical review panel, this may include members of the Clinical Senate Council and Assembly, external experts, and / or others with relevant expertise. It will appoint a Chair of the review panel
ii. consider the review recommendations and report and consider whether the clinical review panel met the Terms of Reference for the review
iii. provide suitable support to the panel
iv. issue the final report to the commissioning organisation and
v. promptly forward any Freedom of Information requests to the commissioning organisation.

Clinical review panel will

i. undertake its review in line with the methodology agreed in the Terms of Reference
ii. follow the report template and provide the commissioning organisation with a draft report to check for factual inaccuracies
iii. submit the draft report to Clinical Senate Council for comments and will consider any such comments and incorporate relevant amendments to the report.

Clinical review panel members will undertake to

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

Clinical review panel members:

Members of the clinical review panel sit in their own personal or professional capacity; they do not represent the opinion of their employing or professional body. All clinical review panel members sign an agreement of confidentiality and declare any potential conflicts of interest. Clinical review panel members names and areas of expertise will be shared by the clinical Senate with the commissioning organisation prior to the pre-panel.

Appendix A – Key Dates		
Action	**Date (no later than)**	**Who**
1. Commissioning team request clinical review – date & methodology agreed with Senate	**11.03.2022**	**Andy Vowles/ Mary Parfitt**
2. Terms of Reference for review completed, agreed and signed off	**18.03.2022**	**Andy Vowles/ Bernard Brett**
3. All panel members identified and confirmed	**18.03.2022**	**Mary Parfitt**
4. All panel members confidentiality agreements and declarations of interest signed (NB for each individual Panel member, individual agreement must be signed and received back by Clinical Senate prior to Evidence Pack being sent to individual member)	**18.03.2022**	**Mary Parfitt**
5. All papers and evidence for the review panel to be received by eoeclinicalsennte.nhs.net	**21.03.2022**	**Andy Vowles**
6. Evidence pack and Terms of Reference to be sent to panel members	**22.03.2022**	**Mary Parfitt**
7. Pre-panel teleconference call	**29.03.2022**	**All Panel Members invited (NB Not MSE)**
8. Key Lines of Enquiry / Agenda for Clinical Panel review meetings issued	**01.04.2022**	**Mary Parfitt**
9. Clinical Panel Review	**04 & 06.04.2022**	**All Panel Members. Potential availability of MSE for questions on 06 April 2022 only**
10. Draft report to MSE (Andy Vowles) for points of accuracy	**05.05.2022**	**Mary Parfitt**
11. MSE response on points of accuracy	**20.05.2022**	**Andy Vowles**
12. Clinical Senate Council consider report	**Date tbc, but to fit in with MSE next stage timelines**	**Bernard Brett**

APPENDIX 2:

Membership of the Clinical Review Panels held on 04 and 06 April 2022

Clinical Review Panel Chairs:

Dr Bernard Brett (Chair of Panel Sessions held on 04 and 06 April 2022)
Dr Bernard Brett MB, BS, BSc, FRCP, Advanced Medical Manager (BAMM) is Deputy Medical Director and a consultant Gastroenterologist at the Norfolk and Norwich University Hospitals NHS Foundation Trust, and also works at the James Paget University Hospitals NHS Foundation Trust. He has a strong interest in Management and Leadership. He is the current Chair of the Clinical Services and Standards Committee (CSSC) for the British Society of Gastroenterology (BSG), recently completed his term as the BSG Quality Improvement Lead and is the regional Endoscopy Clinical Transformation Lead for the East of England.

Bernard has held the post of Chair of the East of England Clinical Senate since July 2014 and has chaired more than fifteen independent clinical review panels. In 2016 he won the Health Education East, 2016 NHS Leadership Recognition Award for 'Leading and Developing People'. He has also held several senior management posts over the last twenty years including the following roles whilst at the James Paget University Hospital; Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal Lead. He previously led the East of England's project to develop a unified drug chart for the region. Bernard has spoken at regional and national meetings on a range of topics including '7-day working' and been an invited speaker on the topic of 'Improving Colonoscopic Adenoma Detection Rates' and 'The Future of Gastroenterology Services.'

His clinical interests include Bowel Cancer Screening (he has been an accredited bowel cancer screening Colonoscopist for the last 15 years); Therapeutic Endoscopy and Endoscopic Retrograde Cholangiopancreatography (ERCP). His educational interests include communication skills and endoscopic training – he is Senior Faculty Member of the Regional Endoscopy Training Centre in Norwich and was on the Faculty for Regional Trainer Development Programme Module, 'Learning and Teaching Communication Skills' for over 10 years.

Dr Hazel Stuart (Chair of Pre-Panel Session held on 29 March 2022)
Dr Hazel Stuart MBBS, DRCOG, FRCA, FICM is Medical Director and a Consultant Anaesthetist with an interest in Intensive Care Medicine at the James Paget University NHS Foundation Trust in Gorleston.

She has had an interest in leadership for many years and has held a variety of posts within the Trust including Transformation Lead, Deputy Medical Director and is also a Caldicott Guardian.

Hazel has been a member of the clinical reference group for Hyperbaric Medicine commissioning and has an interest in diving medicine.

In 2016 she completed the Nye Bevan programme and received a NHS Leadership Academy award in Executive Healthcare Leadership. She has an interest in reflective learning and collaborative working and is an Honorary Senior Lecturer at the University of East Anglia.

Panel Members:

Louise Connolly - Occupational Therapist
A senior allied health professional working in a large Community NHS Trust. Louise is an Occupational Therapist specialising in Neurological Rehabilitation with over nineteen years of operational management experience managing a range of specialist and generalist multidisciplinary teams.

Having 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. Louise has also been leading Discharge Home to Assess pathways during the pandemic and working on the implementation of new COVID system wide pathways. With effect from 01 April 2022 Louise will be moving into a new role as Allied Health Professional Faculty Lead across Herts and Essex Integrated Care System
(Apologies sent for the 04 April 2022 Panel Session)

Charlotte (Charlie) Dorer - Associate Director, Allied Health Professionals
Charlie is a physiotherapist by background, and about to move to a new role to work for NHSE/I as the Senior Quality Improvement Manager for the Stroke Rehabilitation (SQuIRE) project in the East of England.

Charlie has over twenty years' experience in stroke and neurological rehabilitation. She has undertaken both clinical and strategic roles during her career. Charlie's previous substantive role was as a Clinical Lead for Stroke and Neuro Rehabilitation providing her with in-depth subject knowledge and experience across community stroke and neuro rehabilitation. Currently she is in a strategic position working in a Community Trust leading the AHP workforce across all directorates (Community Health and Well-being, Learning Disabilities and Autism and Mental Health). In this role, she has focused on key development themes involving workforce planning on integrated pathways, operational delivery including safer staffing and maximising patient outcomes

Louise Dunthorne – Senior AHP
Since qualifying in 1990 Louise has spent a considerable number of years gaining experience at some of the large London teaching hospitals, including Charing Cross and The Royal London, where her passion for Stroke and Neurology was ignited, while working on the Trauma Unit and Neuro Surgery Critical Care.

Since then, she has specialised in Neurology and Stroke, being involved at Executive Committee level for ACPIN (Association of Chartered Physiotherapists in Neurology) for over ten years. She then completed a Diploma in stroke care in 2004, and Masters level modules in Effective Practitioner, Work based Learning and Work Place Coaching, securing a Post Graduate Certificate in Clinical Practice in 2008.

Louise also held the position of Chair for Regional ACPIN between 2021-15 and was honoured to receive a Distinguished Service Award by National ACPIN in 2016.

Louise works as a Clinical Specialist and Professional Lead for Stroke / Neuro at Ipswich Hospital, (ESNEFT) and Extended Scope Practitioner under a PGD for injecting Botulinum Toxin as part of the Spasticity Management Clinic. She also holds the post of AHP Clinical Lead for North ISDN, (Integrated Stroke Delivery Network). These roles necessitate reporting to ICS Stroke Board, ICS Neuro Rehab Board, East of England Neuro-Rehabilitation Steering Group and the East of England Stroke Programme Board on delivering results towards achieving the vision of the NHS Long Term Plan within Stroke and Neurology care.

Ruth Empson - Specialist Nurse Coordinator for Integrated Stroke ESD & Neuro Rehabilitation Service
Ruth is also the East of England North Integrated Stroke Delivery Network (ISDN) Lead Nurse (Secondment). Previously she was Lead Nurse for Acute Stroke Services at West Suffolk Hospital NHS Foundation Trust and Coordinator for Community Stroke & Neuro Rehabilitation Services, South West London Community NHS Trust.
(Apologies sent for the 06 April 2022 Panel Session)

Louise Gilbert - Advanced Specialist Physiotherapist
Louise is currently working as an Advanced Specialist Physiotherapist in Early Supported Discharge for Stroke (ESD) and has a shared team lead role. She has specialised in Neurological rehabilitation since 1993 working in both the acute and community settings and moved to Norfolk from London in 2007.

Louise completed her masters in Physiotherapy and PGCTLHE at the University of East London (UEL) in 1999 and 2000 and worked as a lecturer in Physiotherapy at the UEL from 1998 – 2003.

She has a keen interest in research and has been fortunate in her current post to have gained experience both as co-applicant, clinical researcher and principal investigator for local and national stroke studies.

Christine Hancock – Expert by Experience
Christine is a retired Social Work Manager and Commissioner who has had 24 years' experience of working with three different Local Authorities in Adult Care planning and procurement. During this time she was involved with implementing the Community Care Act 1990 and the Health and Social Care Act 2012, hospital discharges, care at home, direct payments, supported housing and long term residential/nursing home placements.

Christine has also undertaken residential and supported living reviews for Adults with special needs in the Eastern region in receipt of direct payments and support from their respective Local Authorities

Dr Kneale Metcalf – Stroke Consultant
Dr Metcalf is a Stroke Consultant at the Norfolk and Norwich University Hospital, appointed in 2001. Post graduate training was in Oxford. Kneale led service development in Norwich including establishment of a Rehabilitation Unit and Stroke Early Supported Discharge Service. He is an Honorary Senior Lecturer at the University of East Anglia with a leadership role in final year undergraduate Medicine. He is on the East of England Stroke Telemedicine clinical rota. He retains a research interest with active participation in local and multi-centre stroke trials. Kneale was also appointed as Consultant liaison for Clinical Coding in Norwich in 2021. In 2021 he was appointed Clinical Lead for the Integrated Stroke Delivery Network East of England (North).

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

Dr Deyo Okubadejo MBBS FRCP
Dr. Deyo Okubadejo is a Consultant Physician with an interest in Frailty and Falls and Syncope in Older People. He participates in the Consultant rota for acute and general medical on-call at Peterborough City Hospital. He is currently the Divisional Director for the Emergency and Medicine Division at North West Anglia NHS Foundation Trust and Chair of the East Anglia Region British Geriatrics Society.

Tanya Riddlesdell - Stroke Therapy Lead
Tanya trained at the University of East London and qualified 1994, Junior rotations at St Thomas' and Guys Hospital, Specialising in Neurology & Stroke at King's College London and Addenbrooke's Cambridge. Developed community skills from 2000 working as the Neurophysiotherapist in Intermediate Care across Huntingdonshire + Stroke Ward & Neurology patients in hospital. Tanya developed the Therapy and Rehabilitation Service team bringing a variety of professionals together to find solutions for individuals with neurological impairments in their own homes. Completed a MSc in Advanced Neuro Physiotherapy at UCL, 2007. Managerial

experience as Team Lead for Melton and Rutland Community Hospitals & Community for 18 months, having to leave due to caring duties for in-laws and my son post neurosurgery for epilepsy, alongside part-time work combined NHS, self-employed and case management. Current full-time role as Stroke Therapy Lead at North West Anglia Trust, but leaving to work in Leicestershire in May 2022.

Clinical Senate Support Team:

Mary Parfitt	East of England Interim Head of Clinical Senate, NHS England
Elizabeth Mabbutt	East of England Clinical Senate Senior Project Officer
Christina Wise	East of England Clinical Senate Senior Project Officer

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests.

All panel members certified that:

a) To the best of their knowledge, they did not have any actual or apparent direct or indirect, monetary or non-monetary conflicts of interest which would impair their ability to contribute in a free, fair and impartial manner to the deliberations of the panel, and

All panel members agreed to notify the Clinical Review Chair promptly if:

b) A change occurred during the course of this work

c) They discovered that an organisation with which they have a relationship meets the criteria for a conflict of interest

APPENDIX 4: Review Panel Agenda

AGENDA

Independent Clinical Review of proposal for Mid and South Essex Health and Care Partnership (MSE) Community Inpatient Beds

Discussion to be spread over two panels to be held via MS TEAMS on Monday, 04 April 2022 from 18.00 – 19.30 and Wednesday, 06 April 2022 from 18.00 – 19.30

Clinical Senate is asked to review the available evidence, discuss with panel members and make appropriate recommendations from its findings on the proposals for community inpatient beds put forward by Mid and South Essex Health and Care partnership (MSE)

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

1. **Overall:** Are the emerging options for the future configuration of community inpatient beds likely to result in good patient outcomes and support the flow of patients through the system's beds?

2. **Intermediate care beds:** Is the clinical model for ageing well and the proposed focus and potential locations of community beds aligned with best practice and likely to contribute to improving outcomes for patients?

3. **Stroke:** Is the proposed introduction of dedicated, ring fenced stroke rehabilitation beds in the community aligned with the current evidence base and likely to improve patient outcomes?

4. **Sub-acute Frailty:** Is the model that has been developed clinically sound and likely to result in at least comparable outcomes for frail older people, and how might it be further developed over time?

Monday 4 April 2022 – Panel 1

Time	Item	Lead
17.55	Join Teams Meeting	Panel Members
18.00 - 18.15	Welcome, Introductions & Outline of the Review Panel	Dr Bernard Brett
18.15 - 18.30	Additional information provided by MSE in response to the Draft Key Lines of Enquiry (KLOEs) identified by the Pre-Panel on 29 March 2022	Dr Bernard Brett/ Panel Members
18.30 - 19.25	Confidential Panel Discussion of MSE's Proposals for: • Intermediate Care Beds • Stroke • Sub-Acute Frailty • Overall	Panel Members
19.25	Next Steps for Wednesday 6 April 2022 - Panel 2	Dr. Bernard Brett
19.30	Close	Dr. Bernard Brett

Wednesday, 6 April 2022 – Panel 2

Time	Item	Lead
17.55	Join Teams Meeting	Panel Members
18.00 - 18.15	Welcome, Introductions & update from Panel 1 held on Monday 4 April 2022	Dr Bernard Brett
18.15 - 18.45	Discussion / Questions and Snswers with MSE: • Andy Vowles, Programme Director • Dr Sarah Zadie, Overall Clinical Lead • Dr Steve Waters, Sub-acute Frailty Lead • Dr Kirthi Ramanthan, Stroke Lead • Gerdi Du Toit, Programme Director for Ageing Well	Panel Members/ MSE team
18.45 - 19.00	Confidential Panel Discussion of MSE's Proposals for: • Intermediate Care Beds • Stroke • Sub-Acute Frailty • Overall	Panel Members
19.00 - 19.25	Panel Summary • Key Findings and Recommendations for the 4 key questions	Panel Members/ Dr. Bernard Brett
19.25 - 19.30	Next Steps	Dr. Bernard Brett
19.30	Close	Dr. Bernard Brett

Next steps – information for Clinical Review Panel Members: **1.** A draft report will be sent to the MSE team and Clinical Review Panel Members for a points of accuracy check no later than 19 April 2022, for response by 04 May 2022 **2.** The plan is for the full report to be submitted to Clinical Senate Council on 27 June 2022 to ensure it has met the agreed Terms of Reference and to agree the report. If, in discussion with MSE, the report is required prior to this date, an extraordinary Clinical Senate meeting may be convened. The final report will be issued to the commissioning organisation following the Council Senate Council meeting at which the report is reviewed. The commissioning organisation then becomes the owner of the report.	

KEY LINES OF ENQUIRY

The clinical review panel raised a number of areas for further exploration at its pre-panel call on 29 March 2022. These have been developed into key lines of enquiry (KLOE) for the commissioning organisation to address. The commissioning organisation is invited to address any of these by email prior to the first panel evening to be held on Monday 4 April 2022. Please note, the discussion by the panel will not be restricted to these areas alone.

The KLOE's are:

1. **Overall: Are the emerging options for the future configuration of community inpatient beds likely to result in good patient outcomes and support the flow of patients through the system's beds?**
   - **a) Access & Travel for family, carers and friends**:
     - What scoping of overall supply of transport public services has taken place (e.g. frequency, availability) to factor in potential future changes?
     - How will this work with family engagement in the patient's care?
   - **b) Engagement/feedback:**
     - What engagement with public and patients has been carried out prior to formal consultation?
     - How are MSE going to make it a better service for patients? What measures are being used to evidence this?
     - The panel would like to see more data on outcomes data, specifically in PROMs, PREMs, and SSNAP (accepting some SSNAP is not relevant to the scope of this review).
   - **c) Digital:**
     - The panel would like to see, if available, a projected plan for related digital transformation and sharing of information with all parts of the pathways.
   - **d) Clinical leadership and workforce:**
     - What is the clinical leadership and projected workforce for each of the three proposals?

- What clinical leadership models have been explored and what are the expected opportunities for multi-disciplinary leadership e.g. senior clinical AHP leadership?

e) Hand-off:

- What is the planned future integration back into community services such as primary care and other community teams e.g. DN's, Geriatric Assessment?

f) Future pathways:

- What is the relationship of the proposals to place based care?
- What are the interfaces – is it by geography?

2. Intermediate care beds: Is the clinical model for ageing well and the proposed focus and potential locations of community beds likely to contribute to improving outcomes for patients?

a) Learning from community pilot in Halsted (Care at Home):

- What is the learning from this pilot and what from this learning has been uplifted into the pathway proposals?
- How widespread is this learning envisaged to be across the whole pathways?

b) Pathway development:

- What differentiates the intermediate care pathway from the straight to home pathway?
- What scoping has taken place around integration and use of the voluntary sector?
- How will MSE mitigate the push model?

3. Stroke: Is the proposed introduction of dedicated, ring fenced stroke rehabilitation beds in the community aligned with the current evidence base and likely to improve patient outcomes?

a) Criteria:

- What is the proposed inclusion and exclusion criteria for admission? e.g. Feeding tubes (PEG, NGT)

b) Discharge processes:

- What is the Early Supported Discharge and social care involvement in the pathways?
- Please clarify the content of the rehabilitation pathway in the discharge processes.
- Are there specific pathways for younger patients and if so please elaborate.
- The panel would like further detail on the rehabilitation pathways into the community.

c) Workforce:

- The panel would like to be provided with a more comprehensive staffing model, including medical input for complex care, if available now?
- Is there integration of community and acute staff for stroke?

4. Sub-acute frailty: Is the model that has been developed clinically sound and likely to result in at least comparable outcomes for frail older people, and how might it be further developed over time?

a) The panel would like further information on what services and speciality access to investigations, specialist advice and infrastructure (e.g. oxygen availability, X-ray facilities) will be available to patients in the community inpatient beds?

b) What are the MSE plans to enable and improve on this?

Clinical Review Panel Members		
Name	**Area / Organisation**	**Role / Area of Expertise**
Dr Bernard Brett – Chair	Clinical Senate Chair	
Dr Hazel Stuart – (Pre-Panel Chair)	East of England Senate Council Member	Medical Director, James Paget University Hospitals NHS Foundation Trust
Louise Connolly	Hertfordshire Community NHS Trust	Occupational Therapist specialising in Neurological Rehabilitation, Clinical Quality Lead
Charlotte Dorer	Coventry & Warwickshire Partnership Trust	Associate Director of Allied Health Professionals
Louise Dunthorne	East Suffolk & North Essex NHS Foundation Trust	Senior AHP
Ruth Empson	Cambridgeshire & Peterborough NHS Foundation Trust	East of England (North) Integrated Stroke Delivery Networks Lead Nurse, Coordinator Integrated Stroke Early Supported Discharge & Nero Rehabilitation
Louise Gilbert	Norfolk Community Health & Care NHS Trust	Advanced Specialist Physiotherapist – Early Discharge for Stroke
Christine Hancock		Expert by Experience
Dr Kneale Metcalf	Norfolk & Norwich University Hospitals NHS Foundation Trust	Stroke Consultant & & Clinical Lead, East of England (North) Integrated Stroke Delivery Networks
Dr Stuti Mukherjee	Cambridge and Peterborough CCG	GP, Macmillan GP & Joint Clinical Lead, Cancer
Dr Deyo Okubadejo	North West Anglia NHS Foundation Trust	Consultant Physician in Medicine for Older People & Divisional Director for the Emergency and Medicine Division, Peterborough City Hospital
Tanya Riddlesdell	North West Anglia NHS Foundation Trust	Neurophysiotherapist & Stroke Therapy Lead
In Attendance		
Mary Parfitt	NHS England and NHS Improvement	Interim Head of Clinical Senate
Elizabeth Mabbutt	NHS England and NHS Improvement	Clinical Senate Project Officer
Christina Wise	NHS England and NHS Improvement	Clinical Senate Project Officer

APPENDIX 5: Summary of evidence set provided

Ref	Evidence	Explanation
01	Slide Pack of Evidence	Including: • Summary • Overview & Content • Case for Change • Configuration Scenarios • Improving Outcomes • Workforce • Access • Clinical Engagement & Leadership • Public, Stakeholder & Staff Engagement • Timetable • 5 Data Appendices
02	MSE's response to the Key Lines of Enquiry arising from the pre-panel teleconference held on 29 March 2022	
03	MSE's response to the Themed Questions arising from the first panel session held on 04 April 2022	

End of Report