NHS
East of England
Clinical Senate

Princess Alexandra Hospital NHS Trust

Report of the Clinical Senate independent clinical review panel held on 27 November 2018

Glossary of abbreviations used in the report	
CCG	Clinical Commissioning Group
ICA	Integrated Care Alliance
KPI(s)	Key performance indicators (measures)
MSK	Musculoskeletal
PAH	Princess Alexandra Hospital NHS Trust Harlow (used interchangeably with ‘the Trust’)
STP	Sustainability and Transformation Partnership
The Trust	The Princess Alexandra Hospital NHS Trust Harlow (used interchangeably with ‘PAH’)

Table of Contents

		Page
	Executive Summary	4
1	Foreword by Clinical review panel Chair	6
2	Advice request, background and scope of review	7
3	Methodology and governance	8
4	Summary of key findings	9
5	Conclusion and recommendations	15
Appendix 1	Terms of Reference for the review	18
Appendix 2	Membership of the clinical review panel	26
Appendix 3	Declarations of Interest	30
Appendix 4	Review panel agenda	31

EXECUTIVE SUMMARY

The Princess Alexandra Hospital Trust (PAH) had recently been through a challenging period and had clearly, successfully, worked hard on improving services for patients. However, the Trust was working from an estate that was no longer fit for purpose and recognised that, with workforce pressures and significant planned growth in the area, it needed to look at how, and where, services would be delivered in future. The Trust had asked Clinical Senate to look at its early proposals for a new model of care delivered through the Integrated Care Alliance.

The clinical review panel acknowledged that the proposals it had considered were still in the early stages of development and that the detail would follow. In principle the proposals broadly made clinical sense, but there was disconnect between the evidence, discussion and presentation and it was difficult to identify the detail. Clearly there was a long journey ahead. The panel recommended that the Trust / Integrated Care Alliance should return to Clinical Senate as the proposals developed but in the meantime made the following recommendations:

Recommendation 1

Whilst it supported the proposed direction of travel the panel agreed that from the evidence provided and the discussions at the review panel, the vision for the model, its intended impact, clinical benefits and improved outcomes for patients were not clear. The panel recommended that the ICA / PAH Trust define and describe clearly its vision and the intended impact, clinical benefits and improved outcomes for patients (refer para 5.2.1).

Recommendation 2

The panel recommended that the ICA / PAH Trust develop a plan with a clear timeline detailing the implementation of the in-hospital model, the alignment with development of the hospital estate and development and implementation of the out of hospital neighbourhood model and hubs.

The plan should include description of how, when and what will be measured to test for success and resilience.

Recommendation 3

The panel recommended that the ICA / PAH develop a communication strategy for staff, patients, carers, public and stakeholders to explain the proposals. It should set out the clear vision and clinical ambition for the ICA and PAH, what that will look like, what that means and the benefits to each of the stakeholder groups. In particular it should lay out the improved benefits to patients.

It may be helpful to lay out this information to the stages of the development of the estate and roll out of the neighbourhood and hub model of care.

The panel recommended that specific information about the neighbourhood hubs be included explaining what services the hubs will provide, how patients, carers and public will access them and what will be different from now.

Recommendation 4

The panel recommended that an ICA wide organisational development (OD) strategy be developed as early as possible to understand the workforce and skills required to enable the proposed models of care to function effectively and deliver safe, high quality care with improved outcomes for patients.

The panel recommended that the ICA OD strategy should include plans for workforce recruitment and retention and training and development.

Recommendation 5

The panel agreed that a description of relationship between the STP / ICA / PAH and respective and collective governance arrangements as pertaining to the development and implementation of the in and out of hospital models would have been helpful. The panel recommended that reference to this is made in future information.

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

1. Foreword by Clinical Senate Review Panel Chair

On behalf of Joanna Douglas Vice-Chair of the panel and I, we would like to thank the Princess Alexandra Hospital NHS Trust for asking the Clinical Senate to undertake a review of their early proposals for new systems of care as part of the extensive estate rebuild, and for providing the review panel with information to support the proposals.

Clinical Senates have a unique and critically important role in providing independent clinical and patient focussed constructive recommendations. Our aim in this review was to provide constructive recommendations to enable the Princess Alexandra Hospital team to further develop their ambitious plans to improve outcomes for patients. The panel agreed engagement in these early stages would assist the team in its proposals to provide high quality patient outcomes and experience.

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

On behalf of the panel and the Clinical Senate I would like to wish Princess Alexandra Hospital NHS Trust our continued support in the further development of their plans and we look forward to assisting in the future as and when their proposals are ready for further review.

Dr Stephen Webb

Review panel chair
East of England Clinical Senate

2. Advice request, background and scope of the review

2.1 The East of England Clinical Senate was first approached in June 2018 by Princess Alexandra Hospital Trust (PAH) with an enquiry around whether the Senate could undertake a review for proposals for an out of hospital model as part of new build hospital proposals on the Princess Alexandra Hospital site.

2.2 The hospital sits on the border of east Hertfordshire and west Essex and is within the Hertfordshire and West Essex Sustainability and Transformation Partnership (STP) area. Currently PAH services a population of around 350,000, although there is planned growth of 53,000 new homes in the local area which would inevitably have an impact on the health and care system. The current hospital estate is no longer fit for purpose as a modern District General Hospital. The Trust and system wide partners had applied for capital funding to develop the current estate.

2.3 Initially a panel was agreed for September 2018, but nearer the time the Trust felt it was not ready and so this was deferred until November 2018. The initial request was for the review panel to look at four clinical areas which were planned to move to an out of hospital model as part of the development – musculoskeletal, respiratory, end of life and frailty services.

2.4 The review was intended to provide feedback and recommendations on the Trusts' early thinking and ideas for its in and out of hospital models as part of the estate development. The scope and aim of the review was defined in the Terms of References (see next section and Appendix 1), all other areas were out of scope of this review.

3. Methodology and governance

3.1 Clinical review panel members (Appendix 2) from the East of England Clinical Senate, and patient representatives (experts by experience), were identified and invited to be a panel member. Clinical members were identified according to four clinical service areas indicated in early discussions with the Princess Alexandra Hospital team to be part of the review (Musculoskeletal, respiratory, end of life and frailty). Although the proposals submitted for the review did not subsequently include all four clinical areas, it was decided to proceed with the full invited panel to provide a wide perspective of the proposals. All panel members signed conflict of interest and confidentiality declarations (Appendix 3)

3.2 Terms of Reference for the review were agreed between the Princess Alexandra Hospital NHS Trust (PAH) team and Dr Bernard Brett, Chair of Clinical Senate.

3.3 A pre panel teleconference to prepare panel members and discuss potential key lines of enquiry was held two weeks prior to the review panel.

3.4 The clinical review panel took place on 27 November 2018. The PAH team gave an overview and context setting presentation to the panel and discussed the proposals in more detail.

3.5 Sections of the draft report were sent to clinical review panel members for review and confirmation of accuracy and to PAH team for review for points of accuracy and to Princess Alexandra Hospital team on 17 December 2018 to check for points of accuracy.

3.6 The final draft of the report will be submitted to a specially convened meeting of the East of England Clinical Senate Council on 24 January 2019 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.

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

4 Summary of key findings:

4.1 Princess Alexandra Hospital in Harlow (PAH) sits on the border of east Hertfordshire and west Essex and is within the Hertfordshire and West Essex Sustainability and Transformation Partnership (STP) area. Currently PAH services a population of around 350,000, although there is planned growth of 53,000 new homes in the local area which would inevitably have an impact on the health and care system.

4.2 The panel heard that the condition of the current hospital estate was no longer fit for purpose and presented some clinical and operational risks. PAH has significant workforce pressures; it acknowledged that different ways and methods of working were required to manage demand and also enable recruitment and retention of a high quality workforce.

4.3 The panel acknowledged that the Trust had recently been through a challenging period and had clearly, successfully, worked hard on improving services for patients.

4.4 The panel learned that key stakeholders in health and social care, voluntary and community bodies from across Hertfordshire and west Essex had come together to develop the Integrated Care Alliance (ICA) to *provide "systematic change – one that would bring together GP and hospital care, physical and mental health care and health and social care…."*[1]. The intention of the ICA that NHS organisations would work in partnership with councils, taking collective responsibility for delivering health care across Hertfordshire and west Essex. The panel noted that the ICA had evidently managed to break down barriers to develop its model of care and was making significant strides in developing a system approach.

4.5 The panel agreed that the presentation from the PAH team was helpful and provided a somewhat better understanding of the situation and drivers for change than had been understood from the documents provided as evidence. The panel commented that it had found it difficult to link documents provided as evidence (which appeared to be commissioning documents) to the proposals for the in and out of hospital model. It was also unclear from the documents whether they were

[1] 'Design West Essex' Briefing for Essex health overview and Scrutiny committee, September 2015

provided as either the current position or proposals for future services, but some of this was clarified though the discussion.

4.6 The panel agreed that it would have been helpful to have information and clarity on the connection with, and relationship between, the ICA, STP, respective commissioners, other NHS providers and PAH and where the proposals under review sat in relation to the overall plan for the STP (ref recommendation 5).

4.7 The panel though agreed that it did not get a clear understanding of whether the presentation and proposals were made on behalf of the ICA by PAH or whether PAH was independently putting forward its own proposals that sat within the ICA (ref recommendation 5).

4.8 The panel heard that the principle of the ICA model of care was to support the move of as much acute care as possible to be delivered away from the acute hospital setting. The Trust had recognised that it needed to make realistic choices about what it could, and could no longer, continue to do; it recognised that patient flow (in and out of the hospital) was key in improving performance. The Trust had identified core services, those services that could be centralised and those which could be localised and how, in future, technology may enable further movement of services, including those current networked services with other acute Trusts that could move back into the area. The panel congratulated PAH on looking outwards and not just inwards in considering future options.

4.9 The proposed out of hospital model was structured around obvious geographical neighbourhoods of around 30-50,000 population. The neighbourhoods would have ‘hubs’ based on GP lists, with community teams “wrapped around” GP practices.

4.10 The panel supported the direction of travel to a more self-managing model of care and heard that PAH recognised the amount of work that would be required to move from a medical model to a self-managing one. The panel heard that local bodies had been empowered to think about how things could be done differently, but felt that the proposal was still largely medically based and questioned the level of community service providers’ involvement in the

development of the proposals. It also agreed that the ICA / PAH should ensure that the hubs had common pathways and protocols.

4.11 Although the Trust stated it needed to do things differently, the panel agreed that it did not get a real sense of what would actually be different, or what were the intended outcomes or clinical benefits for patients. There did not seem to be a sense of pace of change, and the panel did not see any evidence of a plan for implementation of the service changes; nor did the panel see evidence of an apparent alignment of the implementation of the clinical proposals with the physical development of the estate (ref recommendation 2).

4.12 The panel agreed that the proposals made commissioning sense and followed national direction but were not particularly ambitious. However, the panel wished to record that it recognised that PAH as a Trust had achieved significant improvement recently from a very challenged position and so it may be appropriate for PAH to have a more incremental approach to ambitious change towards the future. The panel agreed that it would be helpful to identify the degree of ambition (in terms of patient benefits) and wished to encourage PAH to explore opportunities for more ambitious change that the development of the estate would likely create. Clinical Senate would be happy to support PAH with informal feedback on ideas and proposals for ambitious change.

4.13 The panel heard that some key performance indicators (KPIs) were in place to monitor performance and that further KPIs were being developed, but agreed that these appeared to be very much around process rather than indicators of measure of success (of implementation and change) or improved patient outcomes. The panel agreed that appropriate measures to monitor implementation progress and success and intended patient outcomes should be a fundamental part of the plan and should be developed as early as possible (ref recommendation 2).

4.14 The panel agreed that there did not appear to be a structured alignment around the development and implementation of the in-hospital and out of hospital proposals. It expressed concern that without a clear plan there was a risk of loss of drive and actual progress in implementing changes (ref recommendation 2).

4.15 From the discussion, the panel was not clear how the proposals for the development of the hospital estate, the out of hospital model and the neighbourhood hubs were aligned, if at all. The panel agreed that a timeline and clear description of how the different elements came together were essential to provide clarity, together with a description of the governance arrangements showing how they were connected (ref recommendation 2).

4.16 The panel heard detail of recent work on respiratory, musculoskeletal (MSK) and frailty pathways. It heard that PAH had an award-winning track record for end of life care and wanted to build on that knowledge.

4.17 Although it did not have any detail on the current model for MSK for comparison, from the information provided and heard, the panel felt that the redesigned model could be more innovative and would be unlikely to ease patient flow.

4.18 The panel agreed that the evidence it had heard in respect of frailty and respiratory was positive and encouraging and clearly the right direction of travel, but questioned how these pathways would be rolled out into the hubs to ensure equity and ease of access for patients.

4.19 Through the discussion with PAH, the panel noted that some of the pathways had already been formalised and agreed. The panel questioned the purpose of bringing those to the Clinical Senate; it did express some concern that although these pathways were signed off and ready for implementation, there appeared to be a lack of detail on intended patient outcomes.

4.20 PAH advised that as part of the development of the hospital estate it expected to put technology at the heart of service delivery. It had looked at international good practice within and outside of healthcare settings to understand how it could embed technology across the organisation.

4.21 The panel learned that, except for four GP practices, Systm1 was universally used across healthcare providers with social care services due to also come on line soon. The ‘My Care Record’ platform holding patient information was accessible across the health and care organisations.

4.22 The panel agreed that clearly the development of the new hospital was fundamental to the technological changes being able to be put into place and questioned whether the ambition for change was too long term if it was closely tied in to the new build. The panel reiterated the need for clear timelines for the entire programme and each of the workstreams to the PAH team.

4.23 The panel learned of the significant training and development programme in place for medical staff and the plans for developing and upskilling other non-medical hospital staff through the 'Talent for Care' programme. The Trust had recruited 40 new Consultants in the last three years and aimed to be a 'place for opportunity' for staff. The panel heard that a quality first team had been established to look at how good practice could be embedded across the organisation, that PAH was in discussion with the local further and higher education establishments and that an on-site campus training centre for all professions and grades was planned as part of the estate development.

4.24 The panel agreed that, where appropriate, it would be helpful to look at how in future this programme of training and development could be extended to medical and non-medical staff across the wider system to support the out of hospital model (ref recommendation 4).

4.25 The panel did not get a sense of where additional staff would come from to support the out of hospital hubs or whether there had been any modelling of the workforce and skill sets required to ensure delivery of safe, high quality services for patients through the hubs and out of hospital model generally. A thorough understanding of workforce and skills would be fundamental to assist the modelling required to support pathway development and demand management (ref recommendation 4).

4.26 The panel recommended that an ICA wide organisational development strategy be developed as early as possible to identify the workforce and skills required to support both the in and the out of hospital models. The panel further recommended that the ICA / PAH work closely with Health Education England to help identify appropriate recruitment, training and development needs to support the new model of care (ref recommendation 4).

4.27 The panel agreed that visible clinical leadership would be key to driving the implementation of proposed changes through staff engagement and formal consultation. The panel heard that clinicians had been involved in the pathway work but agreed that strong, visible clinical leadership team would be needed to bring staff on board and drive forward the proposals.

4.28 The panel heard the ICA / PAH would be developing its pre- consultation business case for spring 2019; however it was concerned that there was no mention of any communication and engagement strategy for staff, patients, public and other stakeholders. The panel accepted that this may sit within the ICA and was not discussed as the panel did not specifically ask on this matter at the time. (ref recommendation 3).

4.29 The panel recommended that the ICA/ PAH return to Clinical Senate as the proposals developed and more detail was developed. PAH might find it helpful to work through an actual pathway, for example frail elderly given that it has the potential to be a real the major system pressure. This example could encompass in and out of hospital care, be used to demonstrate how the neighbourhood hubs work and show how the new approach would deliver real improvement and specific outcomes for the local population.

End of section.

5. Conclusion and recommendations

5.1 In conclusion, and to provide context for the recommendations made by the panel, the clinical review panel made the following response to the questions asked of Clinical Senate (in the Terms of Reference):

5.2 a) Does the acute service response to the commissioned out of hospital model of care make clinical sense?

5.2.1 Clinical Senate Review Panel response: In principle the proposals broadly made clinical sense, but there was disconnect between the evidence, discussion and presentation and it was difficult to identify the detail. Clearly there was a long journey ahead.

5.3 b) Although the proposals are still at an early stage, does the evidence demonstrate that the in-hospital model of care looks to be sufficiently ambitious to provide efficient, safe, seamless integrated care for patients from a District General Hospital?

5.3.1 Clinical Senate Review Panel response: The panel agreed that the proposals were relatively ambitious considering where the system had come, but it was unclear whether they were sufficiently ambitious for patients or whether there would be any noticeable change. In addition, if many of the changes were based on the premise of using new technology in the new hospital, then the current timeline associated with that was too far into the distant future to be of notable ambition.

5.3.2 The success of the in-hospital model as part of the whole system model of care would be dependent upon the success of the development, implementation and functioning of the out of hospital model, they are mutually inclusive. The panel agreed that it would be helpful to identify the degree of ambition (in terms of patient benefits) alongside a timeline of development of the estate and implementation of the out of hospital model / hubs.

5.4 c) Do the assumptions on the activity shift seem realistic based on the evidence provided? and

5.4.1 d) Will the proposals for the MSK (Frailty, Respiratory and End of Life) pathway deliver an integrated place based model of care?

5.4.2 The panel agreed that insufficient evidence had been presented to be able to provide an informed response to either of those questions.

5.5 The clinical review panel acknowledged that the proposals it had considered were still in the early stages of development and that the detail would be developed. The panel suggested that PAH / ICA should return to Clinical Senate as the proposals developed but in the meantime made the following recommendations:

Recommendation 1

5.6 Whilst it supported the proposed direction of travel the panel agreed that from the evidence provided and the discussions at the review panel, the vision for the model, its intended impact, clinical benefits and improved outcomes for patients were not clear. The panel recommended that the ICA / PAH Trust define and describe clearly its vision and the intended impact, clinical benefits and improved outcomes for patients (refer para 5.2.1 above).

Recommendation 2

5.7. The panel recommended that the ICA / PAH Trust develop a plan with a clear timeline detailing the implementation of the in-hospital model, the alignment with development of the hospital estate and development and implementation of the out of hospital neighbourhood model and hubs.

5.7.1 The plan should description of how, when and what will be measured to test for success and resilience (refer paras 5.3.1 and 2 above)

Recommendation 3

5.8 The panel recommended that the ICA / PAH Trust develop and share a communication strategy for staff, patients, carers, public and stakeholders to explain the proposals. It should set out the clear vision (as per recommendation 1

above) and clinical ambition for the ICA and PAH, what that will look like, what that means and the benefits to each of the stakeholder groups. In particular it should lay out the improved benefits to patients.

5.8.1 It may be helpful to lay out this information to the stages of the development of the estate and roll out of the neighbourhood and hub model of care.

5.8.2 The panel recommended that specific information about the neighbourhood hubs be included explaining what services the hubs will provide, how patients, carers and public will access them and what will be different from now.

Recommendation 4

5.9 The panel recommended that an ICA wide organisational development (OD) strategy be developed as early as possible to understand the workforce and skills required to enable the proposed models of care to function effectively and deliver safe, high quality care with improved outcomes for patients.

5.9.1 The panel recommended that the ICA OD strategy should include plans for workforce recruitment and retention and training and development.

Recommendation 5

5.10 The panel agreed that a description of relationship between the STP / ICA / PAH and respective and collective governance arrangements as pertaining to the development and implementation of the in and out of hospital models would have been helpful. The panel recommended that reference to this is made in future information.

APPENDIX 1: Terms of Reference for the review

East of England Clinical Senate

East of England Clinical Senate

Independent clinical review of the Princess Alexandra Hospital NHS Trust (PAH) plans to deliver the secondary care elements of pathways of care that link, in an integrated way, with the locally commissioned out of hospital model.

DATE: 27 November 2018

Terms of Reference

Clinical review panel members

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

Clinical Review Panel members	
Name	**Role**
Dr Stephen Webb Panel Chair	Consultant in Intensive Care & Associate Medical Director, Royal Papworth Hospital NHS FT. Clinical Senate Council Member
Joanne Douglas Panel Vice-chair	Chartered Physiotherapist, CEO Allied Health Professionals Suffolk Clinical Senate Council Member
Tania Farrow	Community Pharmacist, Chief Officer Suffolk Local Pharmaceutical Committee
Fiona Carey	Expert by Experience, Clinical Senate Council Member
Dr Joanne Farrow	Consultant Psychiatrist, Clinical Director- West Strategic Business Unit, Hertfordshire Partnership University NHS FT. Clinical Senate Fellow
Dr Indrajit (Indi) Gupta	Consultant Older people Medicine, Basildon & Thurrock Hospital
Dr Venu Harilal	Consultant in Rehabilitation Medicine, Medical Director Norfolk Community Health & Care NHS Trust
Dr Sandra James	Specialist Registrar, Public Health England
Lianne Jongepier	Respiratory Physiotherapist. Head of Clinical Quality Transformation, North East Essex CCG
Dr Stephen Kirker	Consultant in Rehabilitation Medicine, Cambridge University Hospitals NHS FT
Dr Ramanathan Kirthivasan	Consultant Physician / Clinical Director in Medicine, Mid Essex Hospital NHS Trust
Sandra Olive	Nurse Consultant Respiratory Medicine, Norfolk & Norwich University Hospital NHSFT
Dr Titilopemi Oladosu	Global Health General Practice Trainee, Norfolk Clinical Senate Fellow
James Potter	Chartered Physiotherapist, Musculoskeletal, AHPS
Karen Smith	Expert by Experience
Penny Wasahlo	Occupational Therapist, Head of Operations Plexus Healthcare
Taryn Walker	Advanced Clinical Practitioner, Ipswich Hospital NHS Trust

Aims and objectives of the clinical review

Princess Alexandra Hospital NHS Trust (PAH) is experiencing a number of sustainability issues; demand, financial, staffing and growth. The condition and capacity of the hospital estate limits PAH's ability to adapt, expand and harness technology advancement in order to address these issues.

In order to achieve PAH's vision of delivering outstanding healthcare to its population, the Trust needs to work with the local health and social care system to develop its role as a modern sustainable, medium sized, secondary care provider within a place based model of care. To support the delivery of these services, a new fit for purpose acute facility requires development and system investment.

PAH is at the beginning of a journey to develop a new acute facility that is fit to deliver patient care for the next 25 years plus. The Trust will be engaging with the Clinical Senate over the lifetime of the programme and aims to seek advice and recommendations on the proposed model of care, the realism of assumptions on which the new acute facility will be designed and the final proposed facility.

Scope of the review

At this point, Clinical Senate is being asked to consider the future role of a modern, integrated secondary care provider including its core acute services.
In order to achieve this, Clinical Senate will be asked to consider the Commissioner's out of hospital care model, the proposed activity shift and the acute in hospital care model, in response to ensure integrated, quality care.

For this panel, Clinical Senate will be asked to consider an example of how the system intends the overall model of care to operate across providers by considering a developed pathway for Musculoskeletal services (MSK).
The Trust will be engaging with the Clinical Senate throughout the progression of the programme.

Out of scope

Commissioners have developed an out of hospital model of care which has been through public consultation and formed the basis of its commissioning strategy, Clinical Senate will be provided with the evidence detailing this model. Whilst Clinical Senate needs to be aware of the out of hospital care model and the proposed shift in activity it is not being asked to assess the out of hospital model of care except for the degree to which it is likely to impact on activity shifts.

Purpose of the review

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

a. Does the acute service response to the commissioned out of hospital model of care make clinical sense?
b. Although the proposals are still at an early stage, does the evidence demonstrate that the in-hospital model of care looks to be sufficiently ambitious to provide efficient, safe, seamless integrated care for patients from a District General Hospital?
c. Do the assumptions on the activity shift seem realistic based on the evidence provided?
d. Will the proposals for the MSK pathway deliver an integrated place based model of care?

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, achieve STP objectives along with 5 year forward view?

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

Timeline

The clinical review panel will be held on 27 November 2018.

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 review will be undertaken 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. Comments/ correction must be received from the sponsoring organisation within **ten working days**.

Final report will be submitted to Clinical Senate Council 24 January 2019 to ensure it has met the agreed Terms of Reference and to agree the report.

The final report will be submitted to the sponsoring organisation following the Council Senate Council meeting of 24 January 2019. The sponsoring organisation forthwith becomes the owner of the report.

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

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, or at a time that is appropriate to the proposals. This will be agreed with the sponsoring organisation.

The sponsoring 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 sponsoring organisation. (note: 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 sponsoring organisation will be responding to the request).

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 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, who are the owners of the final report.

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

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, but is not limited to:

- relevant public health data including population projections, health inequalities, specific health needs,
- activity date (current and planned)
- internal and external reviews and audits,
- relevant impact assessments (e.g. equality, time assessments),
- relevant workforce information (current and planned)
- evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions, STP implementation plans).

The sponsoring organisation 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. be responsible for responding to all Freedom of Information requests.
v. 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 the sponsoring organisation will

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

Clinical Senate Council will

i. appoint a clinical review 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 the review panel
ii. endorse the Terms of Reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the panel and
v. submit the final report to the sponsoring organisation
vi. forward any Freedom of Information requests to the sponsoring organisation.

Clinical review panel will

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

Clinical review panel members will undertake to

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

APPENDIX 2: Membership of the clinical review panel

Clinical Review Panel Chair:

Dr Stephen Webb
Consultant in Anaesthesia & Intensive Care at Papworth Hospital Cambridge
Stephen trained in Anaesthesia and Intensive Care Medicine in Northern Ireland and the East of England before being appointed in 2008 as Consultant in Anaesthesia & Intensive Care at Papworth Hospital Cambridge, the largest adult cardiothoracic centre in the UK.

His clinical, education and research interests lie in cardiothoracic anaesthesia, cardiothoracic intensive care and patient safety. At Papworth Hospital his roles include Associate Medical Director and Staff Governor (Doctors) on the Council of Governors.

Stephen is the Royal College of Physicians' (RCP) Clinical Leader in Quality Improvement responsible for Health Education East of England & Health Education East Midlands. I am also a Member of the National Institute of Health & Care Excellence (NICE) Accreditation Advisory Committee

Clinical Review Panel Vice Chair:

Joanna Douglas
Chief Executive Officer, Allied Health Professionals Suffolk CIC
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:

Fiona Carey
Fiona worked for thirty years in publishing and higher education, mostly at the Open University. She became ‘accidentally active’ on a local and regional basis as part of Addenbrooke’s Cancer PPG, and as Co-chair of the East of England Citizen Senate. Nationally, she has been a member of the Wheelchair Leadership Alliance; is a founding member of the Q Initiative; and has been an Expert Adviser to the DoH on the establishment of the Healthcare Safety Investigation Branch.

She is regularly invited to speak about patient-centred care and co-production at conferences and expos, has helped to design and develop NHS Citizen, and chaired the Wheelchair Services Summit with David Nicholson.

Dr Joanne Farrow
Graduated from Southampton in 2002 and has been a Consultant Psychiatrist since 2012. Her career in a medical management role started in 2014 as the medical lead for acute adult and rehab services. She has been the Clinical Director for adult acute and community mental health services since 2016.

As Clinical Director she is responsible for the management of medical staff, the quality and safety of the services, the operational management of services and strategic planning.
Led a trust wide change management programme and transformed the acute care pathway. This has led to vast efficiencies in the use of inpatient services.

Jo is currently leading a trust wide implementation of the personality disorder pathway which spans across all services. This pathway is being co-produced with service users and carers and she is using best practice and her innovative vision to look at new roles and models of delivering care.

Tania Farrow
Tania Farrow is an experienced Community Pharmacist, having been a practicing clinician within the Community Pharmacy sector for 30 years.

During this time she has also worked in various representative roles, initially as a PEC pharmacist, then later as Chair of the Local Pharmaceutical Committee (LPC). Since 2012 she has held the position of Chief Officer with the LPC, representing community pharmacy contractors across Suffolk in contractual and service commissioning matters and working with local system leaders to support the integration of community pharmacy into the wider NHS.

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

Dr Venu Harilal
For the past year Dr Harilal has been the Medical Director of Norfolk Community Health & Care NHS Trust, which provides community services to a population of 850,000 in Norfolk. He also does clinical sessions as a Consultant in Rehabilitation Medicine at the Colman Centre for Specialist Rehabilitation, one of the specialist services in Norfolk Community Health & Care. His role there is to support the pathway for patients with complex disability following acute neurological injuries. Venu also provides clinical input to the regional wheelchair and Environmental control services. He has been in this role for the last 13 years. His specialist interest is around management of tone in patients with neurological disabilities and using the international classification of functioning as the framework to provide holistic care. His management interest is around patient pathways which focuses on need rather than diagnosis.

Sandra James
A Specialty Registrar in Public Health, currently working with Public Health England to support the system to achieve improvements in population health outcomes and reduce inequalities.

In 2002 Sandra joined the NHS, working initially as a clinical Dietitian in a hospital setting, before specialising in public health nutrition. She has worked within specialist multidisciplinary teams both in England and Wales, providing weight management services, bariatric surgery, and supporting clinical research trials. She has also managed a varied NHS community dietetic service.

Since 2008 Sandra has worked within the public health system, for both the NHS and Local Government. During this time she has supported Primary Care in the prevention of cardiovascular disease, led programmes of work to support improvements in health outcomes for children, young people and maternity services, commissioned sexual and reproductive health services, and led on the development of immunisation and screening programmes.

Sandra became a Specialty Registrar in 2014, and she currently holds a BSc. Applied Human Nutrition, an MSc. Health Promotion, an MSc. Public Health and she is a Diplomate Member of the Faculty of Public Health.

Lianne Jongepier
Lianne is a respiratory physiotherapist with an interest in Long Term Condition management. During her clinical career she led the North East Essex Respiratory services for 15 years and worked in a variety of care settings including Primary Care, Community Care, Secondary Care and End of Life Care. Her leadership positions include Clinical Respiratory co-lead for the East of England (EoE) as well as Head of Respiratory Network (EoE) before she joined North East Essex CCG in Jan 2017 as the Head of Clinical Quality and Transformation. In her current role she is the transformational lead for Respiratory, Diabetes and Cardiology as well as quality lead for a variety of contracts.

Dr Stephen Kirker
Dr Stephen Kirker has been a consultant in rehabilitation medicine at Addenbrooke's Hospital Cambridge since 1997. He has particular responsibility for amputee rehab and the prosthetic and orthotic services, and shares responsibility with colleagues for 8 in-patient neurorehab patients in Addenbrooke's, out-patients and spasticity management. As part of his NHS work, he supports the therapy and nursing team looking after the 25 neurorehab patients at Marbrook Centre in St Neots.

Dr Ramanathan Kirthivasan
Dr Kirthivasan has served the NHS as a consultant in Medicine with an interest in Stroke since 2003. He took a hiatus from NHS for 4 years to set up a comprehensive stroke service in India upon invitation and was helpful in setting up a vision for a national database for strokes in India. He returned to the UK after this and is currently a Clinical Director in Medicine and a Joint Stroke lead in the STP.

Sandra Olive
Sandra has more than twenty years of experience caring for people with respiratory conditions in a variety of clinical settings in Norfolk. A clinical nurse specialist since 2001, she has promoted the development of nurse led services for patients with a range of chronic respiratory conditions and is the lead nurse for the Norwich interstitial lung disease (ILD) service. She established a support group for those living with ILD in 2014.

She has a keen interest in clinical audit and quality improvement and is the departmental nursing Clinical Governance lead, focusing on engaging the multidisciplinary team to share learning and best practice. In 2012, Sandra represented the NNUH respiratory team at the British Thoracic Society Summer meeting, winning an award for innovation for a patient safety project, which improved inpatient oxygen management.

Nationally, Sandra has served on the Association of Respiratory Nurse Specialists (ARNS) & BTS Nurse Advisory Group committees and is currently Vice-Chair of the ILD-Interdisciplinary Network (ILD-INN). Locally, she is an Associate Lecturer with the UEA Schools of Medicine & Health Sciences and a member of Norfolk Respiratory Interest Group, East Anglian Thoracic Society and the regional ILD network.

Dr Titolopemi Oladosu
Dr Titilopemi Oladosu is a Global Health General Practice Registrar in East Anglia. Her interests are medical education, international health, mental health, and health service delivery. Her work on health systems and healthcare access include: the Mobilising Access to Maternal Health in Zambia project (MAMaZ, with DfiD and the Zambian Ministry of Health), and the reviews of barriers to access and mental health legislations within the health system in Southwest Nigeria.

She is an East of England bursary prize winner for further qualification in medical education. She is also a coordinator and trainer for Ask To See Patient, HEE's patient safety and peer-delivered initiative for FY1s training in East of England.

James Potter
James qualified as a physio in 2003 from University of Hertfordshire and is currently Clinical Lead Physio and Operations Manager for AHP Suffolk, a specialist community MSK provider in East Anglia. James has worked in both primary care, secondary care, for the NHS, privately, for sporting teams and for a social enterprise.

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.

Penny Wasahlo
Penny Wosahlo is an Occupational Therapist specialising in Rehabilitation and Palliative Care Service and currently works in the private sector as Head of Operations for Plexus Healthcare. She has diverse clinical expertise and service leadership ranging from Learning Disabilities and Mental Health to acute hospital rehabilitation services including Stroke/Neuro, Cardiology and Respiratory, to Community Rehabilitation services over the last 15 years. For more than 10 years Penny has specialised in Oncology and Palliative Care with experience across this field from acute hospital Oncology and Palliative Care, to Community NHS Palliative Care and into Hospice Care. Penny completed an MA in Hospice Leadership in 2013.

Penny is currently Chair of the Royal College of Occupational Therapists Specialist Section for Oncology and Palliative Care and is a member of the NICE Service Guideline for the Last Year of Life.

Taryn Walker
Taryn qualified as a physiotherapist in 1997 and has specialised in respiratory physiotherapy since 1999. She has worked in a variety of respiratory roles including acute in-patient medical and oncology, acute respiratory care in the delivery of non-invasive ventilation, out-patient respiratory clinics, pulmonary rehabilitation and community COPD out-reach services. In 2003 Taryn co-established a community outreach respiratory team to run an early support discharge COPD service. This was followed by a successful pilot of a community pulmonary rehabilitation service in 2007 which lead to the agreement to fund community rehabilitation in 2009, thus moving the hospital pulmonary rehabilitation service permanently in to the community.

In 2005 Taryn gained a Masters from Southampton in rehabilitation science. From 2004 until 2017 Taryn was a clinical specialist respiratory physiotherapist with extended scope roles and clinical lead for an integrated physiotherapy and occupational therapy service across in-patient and outpatient medical and respiratory services. Seeking new challenges she became an independent non-medical prescriber in 2016 and in 2017 Taryn left the therapy team switching roles to become the first physiotherapist in the Trust to work as an advanced clinical practitioner in acute respiratory care. She has just completed a PG certificate in advanced clinical practice at Warwick University to help to support her as an AHP ACP and is keen to develop her role and to fly the flag for other AHPs to become ACP's in the future. Taryn holds a special interest in the treatment of breathing pattern disorders and chronic cough and has been a committee member of the physiotherapy for breathing pattern disorders group since 2000.

In attendance at the panel: Princess Alexandra Hospital Team:

Michael Meredith

Dr Marcelle Michail

Marc Davis

James Roach

Clinical Senate Support Team:

Sue Edwards	East of England Head of Clinical Senate, NHS England
Penny Thomas	East of England Cancer Alliance

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests. Dr Stephen Kirker declared a direct non-pecuniary interest related to the Marbrook Centre, an independent nursing home / rehabilitation unit in St Neots, Cambridgeshire which had a service level agreement with Addenbrookes's Hospital for Dr Kirker's services and time. Dr Kirker supported the aim of the Marbrook Centre to expand in future. It was agreed at the current level of development of PAH proposals, this would not create a material conflict of interest for Dr Kirker and he was able to remain a panel member.

All other 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 agenda

INDEPENDENT CLINICAL REVIEW PANEL

Sponsoring body:

Princess Alexandra Hospital NHS Trust, Harlow

A G E N D A

Date: Tuesday 27 November 2018 **Time:** 09.15 to 16.30hrs for panel members & PAH team from 10.00hrs to 13.00 hrs

Venue: Boardroom, Granta Centre, Cambridge CB21 6AL

Clinical Senate is being asked to address the following questions:

6. Does the acute service response to the commissioned out of hospital model of care make clinical sense?
7. Although the proposals are still at an early stage, does the evidence demonstrate that the in-hospital model of care looks to be sufficiently ambitious to provide efficient, safe, seamless integrated care for patients from a District General Hospital?
8. Do the assumptions on the activity shift seem realistic based on the evidence provided?
9. Will the proposals for the MSK pathway deliver an integrated place based model of care?

Time	Item
09.15 – 09.30	**Registration & arrival – panel members**
09.30 - 09.50	Welcome, introductions & outline of the proceedings for the review panel from panel chair Dr Stephen Webb

09.50 – 10.00	Princess Alexandra Hospital (PAH) team welcome & introductions
10.00 - 10.30	Overview presentation 30 mins by PAH team to panel
10.30 – 11.15	General questions from panel to PAH team
11.15 – 11.30	Short break
11.30 – 13.00	Panel questions & discussion with PAH
13.10 – 13.40	Lunch
13.40 – 16.00	a) Panel discussion b) Panel summary – key findings and recommendations (to include working break as appropriate)
16.00 - close	Panel summary – key findings and recommendations

Next steps – information for clinical review panel members:

1) A draft report will be sent to PAH team and clinical review panel members for points of accuracy check no later than 11 December with five day turnaround for panel members and seven day turnaround for PAH team.

2) Final draft report will be provided for specially convened Clinical Senate Council meeting on 24 January 2019 for Council to confirm that the clinical review panel met the Terms of Reference for the review (NB Council cannot make any material changes to the report or its recommendations but may make additional comment or recommendations.

3) Final report provided to PAH team by 6 February 2019.