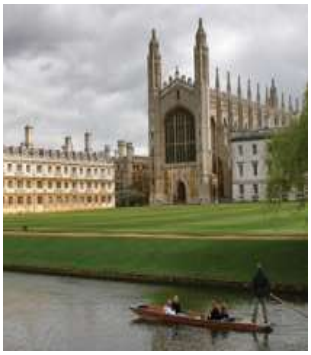

East of England Clinical Senate

Peterborough & Stamford Hospitals Foundation Trust and Hinchingbrooke Health Care Trust

Report of the Independent Clinical Senate Review Panels of 13 & 20 October 2016

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221116 FINAL

Glossary of abbreviations used in the report

A&E	Accident and Emergency (Department)
CPHSCE	Cambridgeshire & Peterborough Health and Social Care Executive
ED	Emergency Department
FBC	Full Business Case (in appendices)
HHCT	Hinchingbrooke Health Care Trust
PSHFT	Peterborough and Stamford Hospital (Foundation Trust)
STP	Sustainability and Transformation Plan

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1. FOREWORD BY CLINICAL SENATE CHAIRMAN

We have been asked to provide an independent clinical review of the clinical proposals described within the full business case for the proposed merger between Peterborough and Stamford Hospital Foundation Trust (PSHFT) and Hinchingbrooke Health Care Trust (HHCT). Both these trusts face significant challenges and they sit within a challenged health and social care system and indeed wider NHS and social care system. Clearly significant work has been undertaken within a very short time frame whilst simultaneously both trusts have been contributing to the development of the system wide Sustainability and Transformation Plan (STP).

The proposals were described as the starting point of a journey to develop sustainable, high quality clinical services which will be significantly further developed both before and after the proposed merger, and through the development of the STP. The initial clinical proposals therefore do not, at this stage, demonstrate major changes to current services and are not particularly innovative. These potential future patient pathways developments were not the subject of our review.

The panels, both at the initial desktop review and the subsequent face to face review, studied the proposals carefully and questioned the PSHFT and HHCT team. The panels recognised the significant challenges and that to do nothing was not a viable option given demand and several services with current sustainability concerns. The panels saw the potential benefit in bringing clinical teams from both trusts together to provide more resilience and sustainability and to support sub-specialities services and training.

I would like to thank the PSHFT and HHCT team for engaging with us in a positive way and responding where possible to all our questions. I would also like to thank all our panel members who were all clearly very much

engaged with the work we had been asked to undertake. They all gave up a significant amount of time to share their expertise, knowledge and wisdom.

We would be only too happy to offer further constructive advice in the future as and when the PSHFT and HHCT team feel this would be of benefit. We wish them well in the future development of their clinical proposals.

Dr Bernard Brett
East of England Clinical Senate Chairman

2. BACKGROUND & ADVICE REQUEST

2.1 Peterborough and Stamford Hospitals Foundation Trust (PSHFT) and Hinchingbrooke Health Care Trust (HHCT) have proposed that for reasons of clinical and financial sustainability, there should be a formal merger of the two Trusts. Subject to full due governance process and approvals this is planned to take effect from 1 April 2017. The advice and recommendations of Clinical Senate on the proposals for the joining up of six specific services (see Appendix 1 Terms of Reference) and the direction of travel is part of that governance process.

2.2 East of England Clinical Senate was initially approached in June 2016 to undertake a review of the integration of a number of clinical services at PSHFT and HHCT. For a variety of reasons that request did not materialise into review panels. A subsequent request to the East Midlands Clinical Senate clarified that the request was for a review of the high level direction of travel proposals of some clinical services as part of the integration programme. This was forwarded to East of England Clinical Senate and it was agreed that, with support from East Midlands Clinical Senate, this would take place as a desktop review on the basis that, initially, there would be very limited change to any clinical services as part of the merger.

2.3 East of England Clinical Senate had also undertaken other, separate, clinical review panels for the Cambridgeshire and Peterborough Health and Care Executive on service change proposals as part of the wider Sustainability and Transformation Plan. Whilst the evidence provided for those panels referred to the proposed merger of PSHFT and HHCT, no detail was given, or considered by, those clinical review panels. Similarly none of the evidence provided for the STP panels in September, including the draft STP, was included or provided for these panels.

2.4 As identified in the Terms of Reference for this clinical review, the integration of the two trusts' clinical services is based on the premise that there would be no adverse change to the model of care offered to patients on any of the three sites. If there were future service changes, these would be part of a wider STP process and would involve appropriate Clinical Senate review and consultation. Any other element of the STP was out of scope for this review.

2.5 Within the case for integration into one trust, the two trust boards have agreed that the merged organisations should address the issues of services identified as currently or potentially unsustainable. Six clinical services were identified for priority focus and 21 further services for high level planning. Those six services the clinical review panel have been asked to consider are: haematology, respiratory, cardiology, stroke, diagnostic imaging and emergency department, only. All other services are out of scope for this review.

3. METHODOLOGY & GOVERNANCE

3.1 On the basis that the integration of clinical services at Peterborough and Stamford Hospitals Foundation Trust (PSHFT) and Hinchingbrooke Health Care Trust (HHCT) would actually involve minimal clinical change, it was agreed with the Deputy Chief Executive Officer of Hinchingbrooke Hospital Care Trust, the lead for the project, that a desktop review of the evidence would be the most appropriate methodology for this clinical review panel.

3.2 It was agreed that the evidence and proposals would be considered at a (first) clinical review panel to be held by teleconference with a follow up clinical review panel made of up of Clinical Senate Council, convened following a Senate Council meeting on 20 October 2016. PSHFT and HHCT were invited to bring representatives to respond to questions from the first review panel to the Senate Council review panel on 20 October 2016.

3.3 Terms of Reference were agreed for the review (Appendix 1). Once the potential panel members had been invited, accepted and had made declarations of interest and signed a confidentiality agreement, they were sent by e-mail/post the documents and evidence provided by the trusts as evidence for the panel review. (Appendices, 2, 3 & 4)

3.4 The clinical review panel convened by teleconference on 13 October 2016 to identify key findings. Initial feedback from the review panel was provided to the project lead following the review panel. These were summarised and provided for the Senate Council review panel on 20 October 2016.

3.5 PSHFT & HHCT representatives attended the Senate Council review panel on 20 October 2016 to respond to questions.

3.6 A draft report was sent to the Deputy Chief Executive of HHCT on 3 November 2016 for review for points of accuracy.

3.7 East of England Clinical Senate Council confirmed that the clinical review panel(s) met and fulfilled the Terms of Reference for the review.

3.8 This report was provided to the sponsoring organisations Peterborough and Stamford Hospitals Foundation Trust and Hinchingbrooke Health Care Trust on 22 November 2016.

3.9 East of England Clinical Senate will publish this report on its website as agreed with the sponsoring organisation in the review Terms of Reference.

4. KEY FINDINGS FROM REVIEW PANEL HELD 13 OCTOBER 2016

General comments

4.1 The panel recognised the strong reasons for the merger of the two trusts and the case for change. The panel agreed that the principles, strategic priorities and direction of travel made sense and supported the clinical vision presented in the full business case. It agreed that combining some teams could lead to some early benefits, particularly in consolidation of workforce and possibly on recruitment and training.

4.2 The panel felt however that the information provided was too high level and general with some broad brush statements. There was limited depth to the plans, reflecting their stage of development, and the case for change would have benefitted from more evidence and detail. Whilst the panel recognised that the plan had been developed over a three month period, this made it difficult for the panel to be able to make informed opinions on the longer term impact of the proposals. The panel understood that the work continues with anticipated further development and detail as the merger progressed.

4.3 The panel had not had sight of the draft Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Plan and it was not provided as part of the evidence for this panel. Whilst some clinical senate council members had sat on an earlier, separate, review panel in respect of some areas of the draft STP, none of those proposals or details of the plan were put before this panel (or that of the 20 October).

4.4 The panel agreed that the evidence should have included more detail on interdependencies, background data, volumes and geographical relationships to other services (whilst recognising the timescales involved as described in 4.2 above).

4.5 The evidence did not make sufficient cross reference to the clinical proposals in the Cambridgeshire and Peterborough Health and Social Care Executive STP and how the proposals aligned with or supported the STP, with reference particularly to the proposals for stroke services which appeared not to align. (*NB: The panel of 20 October was verbally advised that the detail of the draft STP had not been available at the time of developing these proposals).* The panel agreed that it would be beneficial to have evidence of commissioner support for the proposals (*NB*. *A letter was subsequently provided as evidence)* (*See below para 5.2. for verbal response from PSHFT & HHCT team at 20 October panel).*

4.6 Similarly, the panel was concerned that the evidence appeared to imply that no services would be discontinued at either site but additional services would be added particularly on the Hinchingbrooke site. The panel agreed that if that approach led to services, and therefore staff, being stretched too far, that could have a negative effect on patient outcomes and staff recruitment and retention. (*NB: The panel of 20 October was verbally advised that service expansion would be subject to appropriate recruitment of additional staff first and would largely consist of additional outpatient services*).

4.7 The panel found little evidence in the documentation of engagement with either Specialised Commissioning or Papworth Hospital to identify the impact of, or support for, the proposals (cardiology and respiratory particularly). (*NB: the panel of 20 October was verbally advised that both trusts have had and continue to have dialogue with Papworth Hospital but had not yet progressed to discussion with NHS England Specialised Commissioning*).

4.8 The panel was concerned that the proposals for the six services did not attempt to innovate or redesign the services to improve outcomes for patients, but appeared to be just a technical joining up. This approach may well solve some problems quite quickly but could result in more problems in the medium to long term. (*NB: The panel of 20 October was verbally advised that these*

were initial proposals with the anticipation of more significant service redesign pre and post-merger).

4.9 The panel agreed that the evidence would have been strengthened had the proposals been presented in an order of 'flow' and building a story that could highlight the interdependencies i.e. starting with Emergency Department (ED) and working through.

4.10 The panel agreed that the potential (clinical and workforce) risks of the proposed merger had not been identified.

Stroke

4.11 The panel was concerned that the proposals for stroke were not aligned to the proposals previously being considered (but not finalised) for the wider STP. Without full alignment going forward there was concern regarding the longer term sustainability of the services. The panel felt that although proposals were in line with current practice for stroke, the in house stroke pathway was not very modern and lacked innovation.

4.12 The panel noted the proposal to centralise the service but expressed concern about the lack of evidence to demonstrate that there was sufficient capacity to manage at the Hinchingbrooke site.

4.13 The panel was doubtful whether the benefits expressed in the evidence could be achieved through the merger of the two sites alone.

4.14 The panel agreed that the evidence would have been strengthened with the inclusion of information on how repatriation and transfers would be managed and potential impact on the Ambulance Trust. There was no evidence of engagement with or involvement of the Ambulance Trust in developing the proposals and so no evidence of the impact of the proposals on its own plans.

4.15 The panel agreed that further workforce modelling needed to be undertaken to demonstrate that, with the potential increased workload from the merger, a safe, sustainable service could be delivered. While the panel recognised the current difficulty with recruitment of consultants, it was concerned that it could prove challenging to deliver the service with just four consultants. The panel also felt that the need for staff to work on multiple sites could negatively impact on recruitment.

4.16 The panel agreed that there needed to be more focus on rehabilitation.

Emergency Department

4.17 The panel understood that the draft STP indicated that both HHCT and PSHFT would continue to provide 24/7 urgent care with minor injuries and ambulatory care also at both sites. The panel noted however the proposals made no reference to A&E designation / redesignation, and an assumption that the current profile would continue. The panel agreed that clear designation was required and potentially a re-evaluation of the speed of integration.

4.18 The panel agreed that whilst some of the perceived benefits may be realistic, the evidence indicated that retention of consultants particularly remained difficult and therefore raised questions around whether the merger would actually result in a sustainable service at HHCT. Cross working could negatively impact in recruitment on the Peterborough site.

Diagnostic Imaging

4.19 The panel agreed that the evidence would have been considerably strengthened with the inclusion of data on activity and demand for the service.

4.20 The panel felt that a formal merger of the service was not required to bring about the benefits of combined clinical skills and cross cover, and that the greatest benefit would be the joining up of IT systems to support the infrastructure at HHCT.

4.21 The panel agreed that the larger sub-speciality teams could provide more resilience and off site reporting could assist with cross sectional imaging but would not assist with sub-specialised ultrasound or interventional radiology.

Cardiology

4.22 The panel agreed that the case for change was lacking in crucial information including data on volume and activity and the degree of engagement with and involvement of Papworth Hospital and Specialised Commissioning. Without that information, the panel felt unable to support the case for improvement post-merger laid out in the evidence.

4.23 The panel also questioned whether the merger was potentially trying to offer too much at HHCT and recommended that detailed capacity modelling be undertaken. The panel felt that the number of true cardiology cases, excluding those already following urgent pathways to other centres, might be very small and were unsure whether an in-patient cardiology unit was sustainable on the HHCT site.

Respiratory

4.24 The panel felt that there needed to be clarity regarding the dependencies for the service. It found that the proposal for the introduction of some specialist clinics and diagnostics to be introduced at the HHCT site would rely on specific sub-specialist imaging, procedures, equipment and skills that were not currently available. The panel felt that the introduction of these services

might be a significant challenge given recruitment, retention and training issues.

4.25 From the evidence provided, the panel was unclear of the impact on the service when Papworth relocated to Addenbrookes Hospital site and questioned whether the planning was too short term for long term sustainability.

4.26 The panel felt the current dependency for close working with Papworth was likely to continue and the evidence would have benefited from more detail regarding liaison with the trust regarding the future shape of services.

Clinical Haematology

4.27 The panel felt that although there were some potential benefits, the merger could also have a negative impact on the service in PSHFT. (*NB: The 20 October was verbally advised that as the HHCT services would be outpatient and day case only, any potential negative impact on the PSHFT site would be minimised)*.

RECOMMENDATIONS

RECOMMENDATION 1

4.28 The evidence for service change should make stronger and more explicit reference back to the Cambridgeshire and Peterborough Health and Social Care Executive Sustainability and Transformation Plan:

4.28.1 HHCT and PSHFT should ensure the proposed clinical changes are aligned to the wider heath and care system including the STP and Commissioner plans.

4.28.2 This should include the undertaking of risk and impact assessments on its proposals against the STP to ensure that the proposals would not compromise or negatively impact on the wider proposals of the STP.

4.28.3 The evidence should demonstrate how the proposals align with and support the STP, and in particular the proposals for stroke services.

4.28.4 PSHFT & HHCT should demonstrate that the proposals for clinical service change are supported by its commissioners.

RECOMMENDATION 2

4.29 The proposals should be supported with background information and data such as volumes, activity and geographical relationships. Capacity modelling should be undertaken to ensure there is capacity in the proposed model (including workforce) to deliver safe, sustainable services and sufficient activity to clinically justify maintaining current services on all sites.

RECOMMENDATION 3

4.30 PSHFT & HHCT should ensure that all stakeholders were engaged in the planning and have assessed the impact of the proposals on their own plans. Stakeholders should include in particular the Ambulance Trust, Specialised Commissioning and Papworth Hospital and staff.

5. FINDINGS AND RECOMMENDATIONS FROM 20 OCTOBER SENATE COUNCIL PANEL

5.1 Members of the PSHFT & HHCT team ('the team') attended to provide further context and respond to questions from the clinical review panels. The team advised that the merger was progressing and that consultation was not required for any service changes. Integration of clinical services would take place over a two to five year period; the team was looking at other areas to identify good practice, i.e. where clinical integration (between trusts) had been successfully sustained over a period of up to ten years. The intention was to provide "most things to most people" on the Hinchingbrooke site.

5.2 In response to the concern raised by the clinical review panel on 13 October that the merger did not appear to be aligned to the Cambridgeshire & Peterborough Sustainability and Transformation Plan (STP), the team confirmed that although the merger was a part of the overall STP, the approach to keep the merger separate from, and outside of, the STP was entirely intentional. With reference to para 4.5 above, the panel was advised verbally that the STP plans in general and especially for stroke and cardiology were not yet agreed or finalised. The full business case for the merger did make clear that if there were to be significant further changes to clinical pathways as a result of the STP work, these would be subject to appropriate public consultation. *(Para 4.3 also applies)*

5.3 Following up on the concerns of the 13 October clinical review panel, the panel was keen to understand the known or assessed level of impact of the merger on the rest of the system, and in particular the impact of the move of Papworth Hospital to the Addenbrookes Hospital site. The panel was advised that discussions had taken place with Papworth in that respect. There did not appear to have been any discussion with the Ambulance Trust, although the panel recognised that this is more important for the STP work that was likely to involve more significant patient pathway changes (whilst recognising that the plans had not yet been finalised)

5.4 The panel understood that the Haematology service had already merged. (*NB. Post panel it was clarified that the merger was agreed and would be operational from December 2016*).

5.5 Although PSHFT had appointed 11 of the 12 ED consultants, HHCT had only one substantive consultant and the service was currently reliant on locum and bank cover.

5.6 The team advised verbally that Respiratory and Cardiology services would take longer to merge as there were consultant vacancies; the written evidence did not provide information regarding engagement with Papworth Hospital regarding these services, but verbally the panel was advised that several meetings had taken place.

5.7 In response to the concern raised at the panel of 13 October in respect of recruitment and retention of staff, the panel was advised many staff already worked across more than one site. The team advised that it was considered that services were sustainable with consultants providing sessions at each site, although it was noted that consultants on call could not work the 'on site' rota as well.

5.8 The panel heard that a formal Board would be appointed in December 2016 and, once the formal merger of the Trusts was agreed, a clinical integration strategy would be formalised for all sites.

5.9 The panel agreed that the proposal for merger of the two Trusts was sensible and reasonable. However, the panel agreed that the approach at this stage lacked vision and aspiration; there needed to be a more strategic approach to the merger of clinical services to be able to identify real opportunities for innovation and improved services for patients. The panel was verbally advised that further significant clinically lead work was expected pre and post-merger.

5.10 Confirming the concern of the desktop clinical review panel, the members of the panel that had also been a member of the separate clinical review panels for some proposals in the agreed that the merger did not appear to be in alignment with some of the early clinical proposals (seen only by the members of those separate panels) in relation to the Cambridgeshire & Peterborough STP. The panel view was that the merger team should ensure that where possible its plans are in alignment with the direction of travel of the STP.

5.11 The panel supported the finding of the desktop review panel held on 13 October that the written evidence suggested there appeared to have been limited engagement with staff, other trusts (e.g. Papworth, ambulance) or Specialised Commissioning and felt that this was a potential risk to the delivery of services, patient experience and outcomes. The panel was verbally advised that there had been significant engagement with staff, the public and health and scrutiny committees. Engagement with other trusts was through the STP.

RECOMMENDATION

RECOMMENDATION 4

5.12 The panel supported the recommendations of the clinical review panel held on 13th October – recommendations 1, 2 and 3 above. In addition the panel recommended that the team should consider a longer term approach to the merger of clinical services to enable greater innovation of services with more radical options to provide high quality services for patients.

APPENDIX 1: Terms of Reference for the review

East of England Clinical Senate

East of England Clinical Senate

Independent clinical review panel for

Peterborough and Stamford Hospitals Foundation Trust (PSHFT) and Hinchingbrooke Health Care Trust (HHCT)

Desktop review October 2016

Terms of Reference

CLINICAL REVIEW: TERMS OF REFERENCE

Title: **Integration of Clinical Services at Peterborough and Stamford Hospitals Foundation Trust (PSHFT) and Hinchingbrooke Health Care Trust (HHCT)**

Joint sponsoring bodies: **Hinchingbrooke Health Care Trust (HHCT) and Peterborough & Stamford Hospitals Foundation Trust (PSHFT)**

Clinical senate: East of England

Terms of reference agreed by:

Dr Bernard Brett, East of England Clinical Senate Chair

on behalf of East of England Clinical Senate

and

Cara Charles-Barks, Deputy Chief Executive Officer

On behalf of Accountable Officers

Dr Melanie Clements (HHCT), Dr Kanchan Rege (PSHFT)

Date: 21 September 2016

Clinical review team members

Dr Bernard Brett	Clinical Senate Chair
Ruth Ashmore	Assistant Director of Specialised Commissioning, Midlands and East
Sarah Rattigan	Neonatal ODN Director, Rosie Hospital, Cambridge
Dr Andrew Bateman	Clinical Senate Council Member, Chartered Physiotherapist and manager Oliver Zangwill Centre for Neuropsychological Rehabilitation (Ely, UK)
Dr Roy Miller	Clinical Senate Council Member, Associate Medical Director for Clinical Effectiveness and Innovation at Colchester Hospital University NHS Foundation Trust
Prof. Jan Kovac	Consultant Cardiologist University Hospitals of Leicester
Dr David Mangion	Consultant physician in Stroke Medicine at Pilgrim Hospital, ULHT
Dr David O'Brien	Consultant Interventional Cardiologist, United Lincolnshire Hospitals
Joanna Douglas	Clinical Senate Council Member, CEO Allied Health Professionals Suffolk
Dr Stephen Webb	Clinical Senate Council Member, Consultant in Anaesthesia & Intensive Care at Papworth Hospital
Dr Dee Traue	Clinical Senate Council Member, Consultant in Palliative Medicine at East & North Herts NHS Trust
Dr Gillian Bowden	Clinical Senate Council Member, Consultant Clinical Psychologist with Norfolk and Suffolk NHS Trust
Dr Asif Zia	Clinical Senate Council Member, Consultant Psychiatrist and Clinical Director for Learning Disability and Forensic services with Hertfordshire NHS University Foundation Trust.
Dr Sunil Gupta	Clinical Senate Council Member, GP in Essex
John Martin	Clinical Senate Council Member, Director of Patient Safety and Clinical Standards for the East of England Ambulance Service
Dr Alistair Lipp	Clinical Senate Council Member, Medical Director NHS England, Midlands & East (East)

Aims and objectives of the clinical review

The purpose of the independent clinical review is to seek an external clinical opinion on the proposed way forward for the integration of clinical services at Peterborough and Stamford Hospitals Foundation Trust (PSHFT) and Hinchingbrooke Health Care Trust (HHCT).

Scope of the review

Scope of the review

The integration of the two trust's clinical services is based on the premise that there will be no adverse change to the model of care offered to patients on any of the three sites. If there were future service changes, these would be part of a wider Sustainability and Transformation Plan (STP) process and would involve appropriate Clinical Senate review and consultation.

Within the case for integration into one trust, the two trust boards have agreed that the merged organisations should address the issues of current or potential unsustainability of services. Six clinical services have been identified for priority focus, and 21 further services for high level planning.

Out of Scope

The following are outside the scope of this exercise:

- A detailed review of all services
- The wider STP programme for Cambridgeshire and Peterborough, which is the subject of a separate Clinical Senate review.

Questions to the Clinical Senate

In order to support and provide external scrutiny and opinion to the merger and the approach being undertaken to clinical service integration, the Clinical Senate is asked to consider the following questions:

1) For the six services highlighted (haematology, respiratory, cardiology, stroke, diagnostic imaging and emergency department); are there any high level opportunities or unintended / adverse clinical consequences of the merger of PSHFT and HHCT that are not already identified?

2) Do the high level implementation plans demonstrate that the direction of travel would be clinically safe and have the potential to improve the safety and quality of care compared to the current model?

3) Do the risks identified for merger demonstrate there is adequate mitigation and management in place to ensure the continuation of a clinically robust service to local and surrounding areas?

Clinical Senate is asked to review the above questions with particular reference to the six priority clinical specialities.

As agreed with the Clinical Senate the review proposed is a table top exercise on the understanding that no major reconfigurations are proposed.

Clinical Senate will be provided with the following information as supporting documentation to enable it to undertake the review

i. The full business case, in particular the chapter on clinical vision and integration
ii. Integration plans for six identified priority services
    a. Clinical haematology
    b. Respiratory
    c. Cardiology
    d. Stroke
    e. Diagnostic imaging and
    f. Emergency department
iii. The planned approach to clinical integration of the 27 clinical services.

Clinical Senate is asked to review the evidence provided and make its recommendations:

i. Are the proposed models supported by appropriate evidence to demonstrate that it / they have a sound clinical evidence base?
ii. Do the acute reconfiguration options meet the stated goals of redesignate, separate and consolidate?
iii. Does the evidence demonstrate that the proposed high level model will deliver safe, high quality services (subject to development of detailed model and implementation plans)?

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

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

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

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

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

other health and care services, including national policy and planning guidance?

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

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

Timeline

A teleconference will be held on 13 October and the findings considered at Senate Council meeting on 20 October 2016.

Reporting arrangements

The clinical review team will provide an initial report to the Clinical Senate Council for consideration of its findings. Any further recommendations and advice agreed by Clinical Senate Council will be included in the report. The Chair of East of England Clinical Senate will take Chairman's action to confirm that panel met the agreed Terms of Reference and agree the report. Senate Council, as normal arrangements, will be accountable for the advice and recommendations contained in the final report.

Methodology

The review will be undertaken by a combination of desk top review of documentation, followed by a teleconference and further consideration by Clinical Senate Council. Members of the sponsoring body(ies) will not be present at either the teleconference or Council meeting. A separate teleconference will be arranged between the 13 and 20 October to enable the sponsoring body(ies) to respond to any questions from the teleconference.

Report

A draft report will be made to the sponsoring organisation for fact checking prior to publication.

Comments/ corrections must be received from the sponsoring organisation within **ten working days**.

Final report will be submitted to Clinical Senate Council 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 by mid November 2016.

Communication and media handling

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

Resources

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

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

The East of England Clinical Senate is a non statutory advisory body and will submit the report to the sponsoring organisation.

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

Functions, responsibilities and roles

The **sponsoring organisation** 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).

The sponsoring organisation will provide any other additional background information requested by the clinical review team.

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 team during the review.

iv. 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 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 team, this may be formed by members of the Senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.

ii. endorse the Terms of Reference, timetable and methodology for the review

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

iv. provide suitable support to the team and

v. submit the final report to the sponsoring organisation.

Clinical review team 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 team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

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

Summary of process

Stage 1

- Sponsoring organisation (SO) requests clinical review of Senate as part of NHS England assurance process 1
- Senate office 2 review nature and scope of proposals to ensure appropriate for review

Stage 2

- Senate office and SO agree early stage Terms of Reference, in particular agreeing the timeline & methodology
- Senate council appoints Lead member / chair of clinical review team

Stage 3

- Senate office, Senate Chair and clinical review team chair identify and invite clinical review team members
- Clinical review team members declare any interests, these are considered by Senate and CRT chairs
- Clinical review team members confirmed, confidentiality agreements signed

Stage 4

- Terms of reference agreed and signed
- SO provides clinical review team with case for change, options appraisal and supporting information and evidence
- Clinical review commences, in accordance with the agreed terms of reference & methodology

Stage 5

- On completion of the clinical review, report drafted by CRT and provided to the SO to check for factual accuracy
- Any factual inaccuracies amended, draft report submitted to and considered by Clinical senate council
- Senate council ensures clinical review and report fulfils the agreed terms of reference

Stage 6

- Any final amendments made > Clinical Senate Council endorses report & formally submits to sponsoring organisation
- Sponsoring organisation submits report to NHS England assurance checkpoint
- Publication of report on agreed date

APPENDIX 2: Membership of the review panel

Chairman of review panels 13 and 20 October 2016:

Dr Bernard Brett
Deputy Responsible Officer and Consultant Gastroenterologist
James Paget University Hospitals NHS Foundation Trust
Dr Bernard Brett is a consultant in Gastroenterology and General Internal Medicine based at the James Paget University Hospitals NHS Foundation Trust.

His clinical interests include Bowel Cancer Screening (he has been an accredited bowel cancer screening colonoscopist for the last 7 years), Therapeutic Endoscopy and ERCP. Bernard has held several senior management posts including that of Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal lead.

Panel members: 13 October teleconference clinical review panel

Dr Bernard Brett
As above

Ruth Ashmore
Assistant Director Regional Specialised Commissioning Midlands and East (East of England Hub).
Has worked in the NHS for 36 years, Started her career as a RGN but quickly decided paediatrics was for her, undertaking post registration training at Great Ormond Street. Prior to moving into a general paediatric management role she worked in both PIC and NIC services, both regionally and nationally. For the last number of years she has been involved in specialised commissioning and developing networks. She is currently Assistant Director for Regional Specialised Commissioning with responsibility for the East of England Commissioning Hub; commissioning specialised services for the East of England population managing a budget of £1.1 Bn.

Dr Andrew Bateman
Worked in research and clinical rehabilitation since 1990, the year he qualified as a Physiotherapist (East London). Completed a PhD in Neuropsychology in 1997 (Birmingham). Leading the Oliver Zangwill Centre for Neuropsychological Rehabilitation (Ely, UK) since 2002. Special interest in rehabilitation research – specifically outcome research & assistive technology. In the field of neuropsychology he has specialised in areas of executive functioning, dyspraxia & visual perception.

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

Prof. Jan Kovic (requested)

Dr David O'Brien (requested)

Dr David Mangion
A consultant physician in Stroke Medicine at Pilgrim Hospital, ULHT. Qualified in 1978 and had training in internal and geriatric medicine in different hospitals in the UK. Took over responsibility for the Stroke service in 1995.

Dr Roy Miller
Consultant in Anaesthesia
Associate Medical Director for Clinical Effectiveness and Innovation at Colchester Hospital University NHS Foundation Trust. His clinical work is in anaesthesia and pain management and, as well as working at Colchester Hospital, works with community based pain management services in Bury St Edmunds and Colchester.

Sarah Rattigan
With 30 years of nursing experience (general, paediatric and neonatal) Sarah is the Neonatal Network Director. She has held senior management and leadership posts since 1998 covering neonatal and paediatric intensive care units, neonatal transport and paediatrics. The last 9 years have been spent as network lead nurse, deputy director and latterly Director. With a Master's degree in Leadership and the NHS Leadership Academy Senior Leaders Award Sarah is committed to improving the health experience across the system for users and staff.

In attendance at the panel:

Sue Edwards, East of England Head of Clinical Senate, NHS England

Peter Hartshorn, Intern, East Midlands Clinical Senate

Panel members: 20 October Senate Council Review Panel

Dr Bernard Brett
(as previously stated)

Dr Andrew Bateman
(as previously stated)

Dr Gillian Bowden
A Consultant Clinical Psychologist with Norfolk and Suffolk NHS Trust, an Honorary Senior Lecturer with the University of East Anglia and the current East of England branch chair of the Division of Clinical Psychology, British Psychological Society. Has worked in various mental health and learning disability services since 1984. Was awarded an MBE for services to mental health in Norfolk in 2009.

Dr Sunil Gupta
A GP in Essex, a GP Trainer and an Examiner for the Royal College of General Practitioners. He is on the Governing Body of Castle Point and Rochford CCG, on the Essex Employment and Skills Board and a Training Programme Director of the Chelmsford GP Specialist Training Scheme. Sunil is on the Board of the Essex Faculty of the RCGP and a member of the Member of NHS England Primary Care Patient Safety Group. He is a GP Advisor for CQC visits to General Practices, a GP Advisor as part of the RCGP Special Measures Support Team and a Member of NHS England Antimicrobial Resistance Strategy Implementation Group.

Dr Alistair Lipp
Medical Director and Responsible Officer for the NHS England Midlands and East (East) regional team. In this role he is responsible for the appraisal, revalidation and Performers List functions for the GPs in the East area (Norfolk, Suffolk, Cambridge and Essex). He is also supporting the development of primary care - working with other team colleagues.

He is also Head of School of Public Health for Health Education England across the East of England - responsible for the training programmes of specialty registrars in Public Health and also for the public health practitioner registration programme. He is a Board Member of the Faculty of Public Health.

From April 2013, Alistair was the Deputy Regional Medical Director across the whole Midlands and East Region. From 2002, Alistair was Director of Public Health for the PCTs covering Great Yarmouth and Waveney. He originally trained in General Practice and subsequently in Public Health Medicine.

Dr Roy Miller
(as previously stated)

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

Dr Stephen Webb
In 2008 appointed 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 Lead Clinician for Clinical Governance 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.

Dr Asif Zia
A consultant Psychiatrist and Clinical Director for Learning Disability and Forensic services with Hertfordshire NHS University Foundation Trust. He was the chair of the Managed Clinical Network for Learning Disability and Autism work stream for NHS England Midlands and East. His areas of interest include autism, epilepsy and improving health care for people with intellectual disability.

In attendance at the panel:

Joanne Bennis, Director of Nursing Peterborough & Stamford Hospital

Cara Charles-Barks, Deputy CEO Hinchingbrooke Hospital

Dr Melanie Clements, Medical Director Hinchingbrooke Hospital

Deirdre Fowler, Director of Nursing, Hinchingbrooke Hospital

Brenda Allen, Clinical Senate Project Officer, NHS England

Sue Edwards, Head of Clinical Senate, East of England NHS England

APPENDIX 3: Declarations of Interest

Panel 13 October				
Name	**Personal pecuniary interest**	**Personal family interest**	**Non-personal pecuniary interest**	**Personal non-pecuniary interest**
Bernard Brett	None	None	None	None
Ruth Ashmore	None	None	None	None
Andrew Bateman	None	None	None	None
Joanna Douglas	None	None	None	None
David O'Brien	None	None	None	None
David Mangion	None	None	None	None
Roy Miller	None	None	None	None
Sarah Rattigan	None	None	None	None

Panel 20 October				
Name	**Personal pecuniary interest**	**Personal family interest**	**Non-personal pecuniary interest**	**Personal non-pecuniary interest**
Bernard Brett	None	None	None	None
Andrew Bateman	None	None	None	None
Gillian Bowden	None	None	None	None
Sunil Gupta	None	None	None	None
Alistair Lipp	None	None	None	None
Roy Miller	None	None	None	None
Dee Traue	None	None	None	None
Stephen Webb	None	None	None	Declared *
Asif Zia	None	None	None	None

*A Consultant employed by Papworth Hospital Dr Stephen Webb declared a potential conflict of interest. It was agreed that Stephen Webb could be included in general discussions but not specific areas that include Papworth.

APPENDIX 4: Summary of documents provided by PSHFT & HHCT as evidence to the panel

Document submission for Clinical Senate Panel

Document 1a	Full Business Case (FBC) HHCT CEO cover paper
Document 1b	FBC PSHFT CEO cover paper
Document 2	FBC final for approval 20160922
Document 3	FBC Appendices 270916
	Appendix 1 PSHFT – HHCT FBC report Final
	Appendix 2 KPMG LTFM Baseline Report
	Appendix 3 KPMG Transaction LTFM Report
	Appendix 4 20160914 PSHFT response re proposed acquisition
	Appendix 5 ICT Infrastructure (Redacted)
	Appendix 6 Systems and Licensing Review Position Report V1.5
Document 4	Appendix 4 20160914 PSHFT response re proposed acquisition
	Resent to Review Panel Chair 13 November 2016