



East of England
Clinical Senate



Mid and South Essex Success Regime



Report of the Independent Clinical Senate Review Panel

england.eoclinicalsenate@nhs.net

JUNE 2016



(Intentionally left blank)



Table of Contents

1. FOREWORD BY CLINICAL SENATE CHAIRMAN	4
2. BACKGROUND & ADVICE REQUEST	6
3. METHODOLOGY & GOVERNANCE	8
4. GENERAL COMMENTS AND GENERIC RECOMMENDATIONS	10
5. KEY FINDINGS AND RECOMMENDATIONS:	17
Line of enquiry: urgent and emergency care	17
6. KEY FINDINGS AND RECOMMENDATIONS:	21
Line of enquiry: Women ('s services)	21
7. KEY FINDINGS AND RECOMMENDATIONS:	24
Line of enquiry: Paediatrics	24
8. KEY FINDINGS AND RECOMMENDATIONS:	26
Line of enquiry: elective surgery	26
APPENDIX 1: Terms of Reference for the review	28
CLINICAL REVIEW: TERMS OF REFERENCE	29
Clinical Review Team Members	30
SUMMARY OF PROCESS	37
APPENDIX 2: Membership of the review panel	38
In attendance at the panel:	41
APPENDIX 3: Declarations of Interest	42
APPENDIX 4: Key lines of enquiry	43
APPENDIX 5: Summary of documents provided by Mid and South Essex Success Regime as evidence to the panel	47



1. FOREWORD BY CLINICAL SENATE CHAIRMAN

The NHS is facing a very challenging future with a rising demand for services largely through demographic changes, the increasing development of novel therapies and significant financial constraints. The Essex Success Regime is tackling deep-rooted systemic pressures, with the aim of improving health and care in a system that is financially significantly challenged.

The Essex Success Regime do not have the luxury of being able to consider significant capital investment in their estates to facilitate service re-organisation and need to consider key fixed or relatively fixed assets in their forward planning.

Clinical Senates have a unique and critically important role in providing independent clinical and patient focussed constructive advice. Our aim in this review was to provide advice and constructive recommendations to enable Mid and South Essex Success Regime team to further develop their ambitious plans. We believe that if our recommendations are considered with appropriate actions taken this should help ensure that high quality patient outcomes and experience are delivered.

We thank the team for asking the clinical senate to undertake the review and for providing us with a large amount of information. The panel felt that engaging with us at an early stage should assist the team in developing high quality finalised plans.

I wish to thank all our panel members for giving up their time and giving their attention 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 patients.



On behalf of the panel and the clinical senate I would like to wish the Mid and South Essex Success Regime team our 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 Bernard Brett
East of England Clinical Senate Chairman



2. BACKGROUND & ADVICE REQUEST

- 2.1 The Essex Success Regime is one of three such programmes in the country, the others are in Devon and Cumbria. The Success Regime is part of the Five Year Forward View¹, the blueprint for the NHS to take decisive steps to secure high quality, joined up care. It sets out the challenges facing health and care nationally and how radical change is needed to sustain services into the future and improve care for patients.
- 2.2 The Success Regime is concentrating on certain areas in the country where there are deep rooted, systemic pressures. The overall aim is to improve health and care where these systems are managing financial deficits or issues of service quality or both.
- 2.3 A first stage intensive review to assess the challenge and scope for action was undertaken in October 2015. One of the main outcomes was the recommendation that the Essex Success Regime should cover health and care systems of mid and south Essex, as the population served by the NHS in that area was deemed to have a more manageable size and complexity but still allowing change at a large enough scale to have a positive impact.
- 2.4 A System Leaders Group and a Clinical and Professional Leaders Group have been established and Dr Anita Donley appointed the Independent Chair of the Regime.
- 2.5 Three main work programmes were established, reporting to the System Leaders Group. This clinical review panel covers only the acute and associated workstreams (see 2.7 below).
- 2.6 Clinical Senate was approached by Boston Consulting Group on behalf of the mid and south Essex Success Regime late in March 2016 with a view holding a clinical review panel in June to review the initial proposals from the Acute Leadership Group meetings.

¹ Five Year Forward View, NHS England, October 2014



- 2.7 It was agreed that the panel would be asked to look at proposals for Urgent and emergency care, Women's (services), Paediatrics and elective and emergency surgery, recognising that, in addition, there were strong interdependencies between acute clinical reconfiguration and other initiatives in the overall programme, particularly the Frailty pathway.
- 2.8 The approach and clarification of the scope of the request was developed and formalised in Terms of Reference (Appendix 1) and a clinical review panel date set for 14 June 2016.
- 2.9 The scope of the advice did not include the East of England clinical senate formulating or proposing any alternative options, nor did the scope of review consider any financial implications, either negative or positive.
- 2.10 The clinical senate is asked to advise whether **“In the context of the case for change and national recommendations for care models, the proposed "options" for the reconfiguration of services between Mid Essex Hospital Trust, Southend University Hospital Foundation Trust and Basildon and Thurrock Universities Hospital Foundation Trust constitute reasonable proposals to improve clinical outcomes, ensure a sustainable workforce and improve efficiency and productivity?”**

Key questions for the panel to consider included:

Did the ideas make clinical sense given the health need, health service need and clinical standards / evidence?

Are there other impacts that should be assessed or other unintended consequences that have not been mentioned?

And, 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.



3. METHODOLOGY & GOVERNANCE

- 3.1 The scope of the review was discussed with the Mid and South Essex Success Regime (MSESR) through Boston Consulting Group (BCG) to identify the most appropriate expertise for the review panel and also the approach to be taken.
- 3.2 It was agreed that a desktop review of the evidence followed by a single panel day with representatives from the MSESR was the most appropriate approach. It was agreed that, at this stage, site visits would not add any additional value or information to the evidence provided.
- 3.3 Terms of reference for the review were drafted with BCG, agreed and signed by Dr Ronan Fenton, Medical Director, Mid Essex Hospital Services NHS Trust on behalf of the Mid and South Essex Success Regime, and Dr Bernard Brett, Chair of East of England Clinical Senate and appointed Chairman of this review panel.
- 3.4 Senate council support team identified clinical review panel members (Appendix 2) from the East of England clinical senate and patient representatives. 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 BCG as the evidence for the panel review.
- 3.5 A pre-panel telephone conference with panel members was held one week prior to the panel day to identify the key lines of enquiry for the panel day in order that focus could be kept to the Terms of Reference of the review.
- 3.6 The key lines of enquiry were finalised and produced with the agenda (see Appendix 4) for the panel day, and circulated to the panel members and MSESR team prior to the panel day itself.



- 3.7 The clinical review panel took place between 09.30a.m. and 5.00 p.m. on Tuesday 14 June 2016. Mid and South Essex Success Regime was invited to make a short initial presentation to provide context for the evidence submitted, followed by a short presentation for each workstream. The panel then followed up with questions after each presentation following the identified key lines of enquiry.
- 3.8 A draft report was circulated on 14 July 2016 to panel members and the BCG for matters of accuracy.
- 3.9 This, final report, was submitted to a specially convened meeting of the East of England clinical senate council on 27 July 2106 for it to ensure that the clinical review panel meet and fulfilled the Terms of Reference of the review.
- 3.10 This report was then submitted to the sponsoring organisation, Mid and South Essex Success Regime on 3 August 2016.
- 3.11 East of England clinical senate will publish this report on its website as agreed the sponsoring organisation, the Mid and South Essex Success Regime in the review Terms of Reference.



4. GENERAL COMMENTS AND GENERIC RECOMMENDATIONS

Key findings:

- 4.1 The panel complimented the Mid and South Essex Success Regime (MSESR) on the evidence provided for the review panel. The panel recognised the scale of the challenge and congratulated the team on the amount of work already undertaken in the timescale.
- 4.2 The panel welcomed the presentation from the MSESR team on the (out of hospital) Frailty workstream, which had not been included in the evidence pack provided. The presentation and information had been helpful in filling in some of the gaps in the evidence already seen for the other workstreams which had been raised as questions by the panel.
- 4.3 The panel agreed that given the scale of the challenge, this was a real opportunity, and possibly the only opportunity for some years, to make a real difference. The proposals were still in early stages of development and looked to offer some opportunities to meet the challenges in the system. With the proposal for a single clinical team and single commissioning group across the three sites, the panel considered that there was scope to be more radical with some of the proposals and urged the team to consider reviewing some areas for other options. This view was with the panel's focus on assisting the MSESR in developing high quality sustainable services, where attempting to keep services on all or most sites may be less viable, and indeed safe, than more radical change.
- 4.4 The panel noted that although the evidence was overall of very high quality, there was some inconsistency in terminology across the evidence, in particular around neonatal care, and recommended that the team look to be more consistent in the terminology and apply the most current terminology particularly for the neonatal care levels one to three.
- 4.5 The panel felt it would have aided discussion and understanding of the proposals had there been clearer nomenclature of sites. In particular, it



wasn't clear if sites A, B and C documented in the evidence referred to the same hospitals in different workstreams and, in some cases, hospital names were used rather than letters. Furthermore, particularly as the proposals advanced, it would be helpful to see an overview grid demonstrating how different options from each workstream would impact on each other (e.g. obstetric services and paediatrics etc.).

- 4.6 Overall the panel agreed that there had been little cross referencing of work and this needed to be developed. The models and proposals needed to be carefully reviewed and assessed both separately and together, for impact on other services, inter-dependencies and impact on (reducing) health inequalities.
- 4.7 The panel felt there were gaps in relation to information and planning for long term conditions and palliative care particularly and a lack of information for mental health and CAMHS services, all of which have a significant impact on urgent and emergency care.
- 4.8 The panel was concerned to the repeated reference back to the Northumbria model. Whilst it recognised the need to look at and work to best practice models, the panel felt that there was little commonality between the newly built Northumbria Specialist Emergency Care Hospital and the three mid and south Essex sites and that comparison of the two could be misleading in developing pathways.
- 4.9 The panel felt that the scale of work in relation to transport to support and enable the proposals had been under-estimated. There was minimal detail so far regarding the actual numbers as a result of pathway changes but with the proposals for the various sites, there would be a significant impact on the number of inter-hospital transfers including repatriation of patients and the transport required to deliver this, which would need to be on seven day availability.
- 4.10 The proposals, if implemented, would require some considerable staff movement both on a day to day basis and on a more permanent basis. The potential impact of these changes and how they would be supported are not



covered in the evidence, and staff may or may not be reluctant to accept such changes for a variety of reasons. The panel felt there would be benefit in drawing up and communicating some clear principles and / or guidelines covering how staff relocation would be supported. There also needed to be some very early conversations with staff about the proposals including the potential impact on staff movement and how that would be managed and staff supported. Failure to start early could result in incremental drift of staff; clear supportive principles, early conversations and understanding of staff groups and indeed each individual's ability and willingness to move could (in some cases) inform pathway development.

- 4.11 In connection with that, the panel felt that the level of organisational development and change management work had potentially been underestimated (this was not covered in any significant way within the evidence provided although was mentioned during discussion). It would require robust clinical and non-clinical leadership and the panel felt it would be beneficial to identify those leaders now, and, connected with the communication strategy (see recommendation 7 below) to start this work as early as possible. Getting patients, media and particularly staff engaged at the very early stages of change should result in more advocates for change able to take this forward.
- 4.12 The panel heard that the models had been developed around three particular 'givens' i.e. services where the capital cost of relocation of equipment particularly was considered (by the team) to be prohibitive. The panel recognised that with no significant additional infrastructure, the challenge was difficult. However, given the scale of change required, the panel felt significant restructuring of existing infrastructure should be considered to facilitate more marked service change. Centralising a service on a single site or even two sites was likely to be constrained by the existing capacity of the estate for services. The panel found it difficult to make a more detailed recommendation without having more information regarding the existing estate or finalised proposed clinical service changes.
- 4.13 Shared Information and management technology (IT) would be crucial in enabling cross-site working, enabling the smooth transfer of patients and



indeed to aid links with the primary care, mental health and community services. Furthermore reliable and timely information sharing will be extremely important to support the Frailty pathway. MSESr advised that this workstream would be commencing the following week. The panel recommended that the work on the information and technology systems needed to support the changes and services was built into the modelling at the earliest stage.

4.14 RECOMMENDATIONS

RECOMMENDATION 1

4.14.1 The panel urged the team to give consideration to more radical options particularly for urgent and emergency care but also for obstetric care and paediatrics. The panel felt in particular that some of the proposals were neither 'here nor there', i.e. offering more than a walk in centre but not a full Emergency Department service. Enhanced services on some sites whilst retaining services on all sites would potentially not resolve some of the identified sustainability and workforce issues. In addition changes to one service may impact on the viability of other services. Given the scale of challenge there is an opportunity now to determine the optimal configuration of services to meet some of the considerable challenge in the system. The panel recognised that the degree of potential change was challenging and required careful engagement with the public, patients and staff.

RECOMMENDATION 2

4.14.2 Further work and detail is required on the impact of interdependencies with partner and periphery organisations and also on unexpected patient flow, (including the impact on transport covered in Recommendation 3 below). Existing patient flows include those into and from London, the rest of Essex, Hertfordshire and Cambridgeshire. Not only will service change in Mid and South Essex impact on these health and care systems, the converse was also true.



RECOMMENDATION 3

4.14.3 The panel recommended, as a priority, the team should develop further detail on the impact on patient transport, that this be considered during clinical pathway development at the earliest stages. This should include expected numbers but also should include specifically the management of the transfer of critically ill patients from one site to another. Detail should include how transfers would be managed and coordinated, the impact on patients and relatives, particularly those who have mobility impairment and / or rely on public transport needs to be considered and addressed. The panel recommended that the team involve the Ambulance trust in that work from the start.

RECOMMENDATION 4

4.14.4 The panel felt that more modelling needed to be done taking into consideration changes in patient flows i.e. closing or moving some services would require larger numbers of patients to go elsewhere. Modelling needed to inform pathway development to ensure the changes did not create capacity issues. This should include the impact on trusts on the periphery of the area.

RECOMMENDATION 5

4.14.5 The panel recognised that this was still early stages but recommended that the team start to define what they expect the implemented proposals to achieve in terms of improved outcomes especially for patients. There needs to be clear definition of how and when and what will be measured. It was likely that much of this was already being collected and there was unlikely to be a need to develop many, if any, new measures but there needed to be clarity on how outcomes would be measured and reported.



RECOMMENDATION 6

4.14.6 The panel agreed that the information provided from the presentation on the Frailty workstream should be included in detail in the evidence pack. In addition the panel recommended that there needed to be more detail on the connections between and the pathways for frailty, long term conditions and palliative care. Similarly there had been little detail on mental health provision and this needed to be factored into all pathways, particularly frailty, long term conditions and women's services

RECOMMENDATION 7

4.14.7 The team should develop a communication strategy, once proposed service and pathway changes are determined, to inform and educate patients, staff and media. There needs to be clarity and consistency with language and terminology to make sure services are understood. Staff, patients and the public need to have sufficient understanding regarding what the new services would look like, how they would work, where they would be located, how they were accessed and what would be the benefits of these compared to current services (and locations).

In addition, staff needed to be reassured about their roles and work locations and supported through transition and change. The panel recommended that conversations with staff start as soon as possible to help understand the capacity of staff to move with any service relocation.

RECOMMENDATION 8

4.14.8 The panel recommended that an organisational development strategy be developed as early as possible. The team had not made clear whether there were sufficient staff from all three sites to cover the proposed splits in service and agreed this needed to be detailed and recommended that the OD strategy should be informed by a detailed workforce analysis of both current position and the desired position, so that appropriate levels of staff are identified to increase capacity where it would be needed.



In addition, consideration must be given to the training and development of staff and the impact of moving services to different, or single, sites.

Appropriate and varied training provision was crucial to retaining and attracting new staff and the panel recommended that training, recruitment and retention of staff was factored in to the organisational development strategy.

RECOMMENDATION 9

4.14.9 The panel recommended that a detailed organisational development strategy be developed to cover the whole of the mid and south Essex health and social care system. This should include a change management strategy.

RECOMMENDATION 10

4.14.10 The panel further recommended that a detailed workforce plan was developed. This should include all relevant staff groups, current and predicted requirements and areas where there was a risk of a shortfall in workforce. Supporting strategies to the workforce plans should include recruitment and retention strategy, staff engagement and staff development strategies.

RECOMMENDATION 11

4.14.11 MSESER had explained that the Clinical and Professional Leaders Group had developed the options presented to the panel and that involvement of a wider clinician cohort was the next planned stage of development. The panel recommended that the MSESER demonstrate more active engagement with others in the health and social care system especially including local authorities and also other relevant bodies, to ensure that the proposals were system wide and that essential and fundamental elements of the system (e.g. social care) were considered as part of the pathway and model development.



5. KEY FINDINGS AND RECOMMENDATIONS:

Line of enquiry: urgent and emergency care

- 5.1 MSESr were clear in their presentation that continuing with the current state across the three sites was not an option, that local hospital emergency care services were not currently meeting workforce and performance standards.
- 5.2 The team had undertaken high level bed modelling but had not looked at productivity gains or staffing at this stage. The model had been developed by surgeons, with the 'givens' as the starting point. The team considered that the number of beds and theatres available across the sites was not an issue, but that they needed to be used more effectively.
- 5.3 The team also advised that it had not looked at critical care in any depth at this stage, although it recognised that critical care needed to be co-located with complex surgery.
- 5.4 The panel heard that there was an intention to have 24/7 selective emergency departments at all three sites, a single 'specialist emergency hospital', and a frailty assessment unit at all three sites. Outpatients and day care would also be at all three sites.
- 5.5 In the proposed model, elective and emergency surgery was split; the emergency centre would carry out only a minimal amount of elective work.
- 5.6 The team and panel discussed at some length the proposals for the three 'emergency' departments, the inter-dependencies of support services, transport and transfers, and staffing. As noted in para 4.5, without the detail of which services were proposed to be at which site and with which other support services, it was difficult for the panel to provide feedback or recommendations on actual models.



- 5.7 The panel felt that the link with frailty and turnarounds at the door needed to be more robustly estimated, for example the projected 30% increase of turnarounds from the Frailty Assessment Unit (FAU) would mask the number that would have been turned away from A&E if the FAU had not been there. Understanding the real numbers was crucial to the new model being successful in improving outcomes.
- 5.8 There was some degree of confusion around the proposed 'Specialist Emergency Care Hospital', '24/7 selective emergency department' and Essex 'Urgent Care Centre'. Aside from the confusing and sometimes inconsistent terminology, it was not clear how patients would understand where to go for appropriate treatment; how patients would be transferred from one to another if they had inappropriately attended.
- 5.9 The panel was concerned about the staffing for the three different centres and whether there was capacity across the existing consultant and nursing team to ensure safe and required staffing levels.
- 5.10 A number of the panel recommendations for the urgent and emergency care proposals are included in the generic findings section (recommendations one to 11), however the panel was clear that it wanted to reiterate its recommendation for a more radical approach and also to provide other recommendations specific to this workstream.



5.11 RECOMMENDATIONS

RECOMMENDATION 12

5.11.1 The panel agreed the MSESr should review the options for urgent and emergency care and consider a more radical approach to its proposals. The panel was not suggesting any particular model but panel members recognised that this was an opportunity to shape in a different and more radical way. High quality safe, sustainable care had to be the priority but in some instances more minor changes, to enable the retention of current services on all sites, may be less sustainable and less safe. The panel recognised that engagement with the public, patients and staff may be more challenging with such proposals and the level of risk of little or no change to sustainability, quality and safety would need to be articulated.

RECOMMENDATION 13

5.11.2 Critical care needs to be considered throughout the proposals – this is in relation to both the capacity of Intensive Care Units, Critical Care outreach services and in relation to the ability to transfer critically ill patients from one site to another. Significant changes to the pathways of emergency care and complex patients will impact on the critical care needs on each site.

RECOMMENDATION 14

5.11.3 The panel agreed there was a lack of hard data supporting the proposals and recommended that there needed to be more robust data capture and analysis. This should include the number of A&E attendances, including data for current attendance levels after midnight and ambulance arrivals by site. It should also include projected numbers. A review of postcode of past patients would help identify 'catchment' area demand for urgent and emergency care services under the new model. This would assist in understanding capacity requirements.



RECOMMENDATION 15

5.11.4 A detailed workforce model should be drawn up describing current and projected workforce, potential gaps, the approach taken to facilitate re-location, the impact on proposed options and approach to enhanced recruitment and retention. The final options selected should help establish a sustainable workforce model. The team should build in resilience to its workforce model.

RECOMMENDATION 16

5.11.5 Should the team decide to continue with the options proposed it should engage with the Ambulance Trust as early as possible to understand the impact of the model on the service and work with the Trust to proactively manage that.

RECOMMENDATION 17

5.11.6 There will naturally be resistance from the public to any changes to local services and provision and the recommendation 7 on communication was crucial to the success of the urgent and emergency care changes. The current terminology was confusing and the panel recommended that the terminology for the respective centres be consistent and clear i.e. that it says what it does and when it does it. The recommendation to be more radical could assist with the definition and terminology of the respective U&EC centres. It was also recommended that the term 'triage' could be replaced with 'selection'.



6. KEY FINDINGS AND RECOMMENDATIONS:

Line of enquiry: Women ('s services)

- 6.1 The panel noted that the evidence and options presented for Women's service had primarily focussed on obstetrics and maternity. The options had lacked reference to, detail on and options for, gynaecology and the interface between gynaecology and obstetrics. There had also been little reference to non-pregnancy related gynaecology.
- 6.2 There was some panel discussion regarding the interface between gynaecology and obstetrics and the question of when did gynaecology become obstetrics, an example discussed in particular being miscarriage. Reference was also made to the need to consider the link with the overall Urgent and Emergency care options and the location and availability of Obstetricians, in reference to (for example) a walk-in miscarriage.
- 6.3 Expert panel members advised MSESr that incorrect terminology had been used for the various maternity units and neonatal units. Other terminology had also been used inconsistently which had raised some concerns for the panel as to the robustness in planning the options.
- 6.4 There was considerable discussion around provision of the three levels of neonatal care, including the need to tie in closely with paediatrics to ensure safe and appropriate medical cover.
- 6.5 The panel advised that nationally, standalone Midwife led units (MLU) whilst a popular idea among mothers-to-be, were not always used as much as planned or expected; women often choose to attend units that have obstetric services on site.
- 6.6 There was a need for more information and detail about transitional care i.e. the need for enhanced (baby) care next to the mother. Consideration of this



in the options could reduce the need for (more costly) specialist care cots. Such provision though would need input from paediatrics.

- 6.7 The panel felt that a risk of a single site model with specialist care and support services was capacity and the impact on remaining sites.
- 6.8 In the panel's opinion, option one may not be workable due to workforce issues (enhanced cover required at the SOLU would potentially deplete available staff to cover the OLU's unless there was a significant increase in consultant staffing); option two, based on the information provided was more likely to be viable but a neonatal unit (either Special Care Unit or Local Neonatal Unit) would not be necessary and/or sustainable. A Midwife led unit on site C needed further modelling to determine its viability.
- 6.9 The panel discussed with the team the option of sites A & B having an MLU with transitional care alongside, although the capacity issues and interfaces to paediatrics, gynaecology and obstetrics still remained and would need to be worked through and resolved. The panel understood the lack of capital funding to facilitate changes but felt that some upgrading and up-scaling of units would almost certainly be required if services were consolidated onto fewer sites. The panel recognised that these options all depended on which (hospital) sites A, B and C were located, and without that detail the panel was unable to offer further recommendation.

6.10 **RECOMMENDATIONS**

RECOMMENDATION 18

- 6.10.1 MSESr should review its use of terminology, and ensure it applies current, common, accepted terminology consistently throughout its planning, evidence and information documents.

RECOMMENDATION 19

- 6.10.2 The options should include non-pregnancy related gynaecology services and include detail on the interface between gynaecology and obstetrics.



RECOMMENDATION 20

6.10.3 The panel recommended a more thorough data analysis regarding Maternity services and potential reconfiguration with pathway changes. The panel recommended the team should factor in the potential for unplanned unit closure and peak and trough activity as well as mean activity data should be included in the analysis. The team should ensure it has modelled the impact on existing sites within and outside Essex if one site were to be closed or re-classified. The panel recommended that the team undertake more detail on transport time, particularly for rapid transfer and the impact on ambulance and transport services. The options would benefit from a simulation for rapid transfers at different times of day.

RECOMMENDATION 21

6.10.4 The panel recommended that the team should undertake more thorough review and analysis of whether a stand-alone Midwifery Led Unit would be viable with particular focus on trying to determine the likely activity that would flow through it, taking into account the experience of similar units elsewhere in the country. Looking to national guidelines, the team should work up in more detail the pathways, training and staffing requirements to further assess the viability of a standalone MLU with the expected or planned number of users.



7. KEY FINDINGS AND RECOMMENDATIONS:

Line of enquiry: Paediatrics

- 7.1 There was insufficient level of detail provided in the evidence for the panel to fully consider the options; the team and the panel agreed that a lot more work was needed on the options for paediatrics.
- 7.2 The panel understood that around 60% of paediatric surgery occurred following emergency admission. No information was provided around the sub-speciality work on both an emergency and elective basis. The panel suspected that current volumes per speciality on each site were small. There needed to be more data regarding numbers of children currently treated and under proposed changes on each site.
- 7.3 There needed to be more detail on the links to obstetrics, co-location and interdependencies, particularly anaesthetics, urgent and emergency care and paediatrics. As neonatal surgery is only performed in tertiary centres with Neonatal Intensive Care, it would not be likely to be provided on any of the sites. The panel discussed the impact of reducing the number of anaesthetists on any site that routinely undertook paediatric cases and how this could impact on emergency work.
- 7.4 Reference was made in the evidence and options to a 'High Dependency Unit'. As this was not currently a commissioned service in the area, there was discussion on the terminology and meaning in the evidence and options and the team agreed to review.
- 7.5 The panel was concerned that the options had not had sufficient modelling around workforce generally and in particular for any spread across the sites or for proposed level of urgent and emergency care cover. A sustainable workforce plan might not support 24/7 cover on each site. In considering rotas the plan to support combined or split general and neonatal cover needed to be considered and made explicit in future plans.



7.6 RECOMMENDATIONS

RECOMMENDATION 22

- 7.6.1 The options needed to be clearer about co-location of paediatrics with obstetrics, neonatal care, paediatric assessment units and/or Children's Emergency Department and general urgent and emergency care. Other inter-dependencies need to be considered and described. There needed to be a plan of access to care from pre-term to 16/18 across the geographical area.

RECOMMENDATION 23

- 7.6.2 The panel recommended there needed to be more robust data on paediatric elective surgery, anaesthetic cases and modelling of the impact on other specialities. It was concerned that some of the data used had been coding data rather than commissioning data and information.

RECOMMENDATION 24

- 7.6.3 There should be more robust modelling of workforce (see 7.5 above). The panel recommended that pathways and protocols be worked up as soon as possible to support the modelling and options.



8. KEY FINDINGS AND RECOMMENDATIONS:

Line of enquiry: elective surgery

- 8.1 As elective and emergency surgery were inextricably connected, there had been considerable discussion regarding elective surgery in the earlier session on urgent and emergency care. From that discussion, the panel understood and had discussed at some length, the proposal to split elective and non elective surgery.
- 8.2 The panel felt that the detail and data it had been provided with had been limited. It recognised, and agreed with MSESr, that the 19 inter-dependencies identified need to be worked through to be able to put some detail on the options. With that caveat, the panel was generally supportive of the principle of consolidation of both complex and 'blue light' surgery. The panel was also broadly supportive of developing high volume, high expertise centres.
- 8.3 While the panel heard that there would be a joined up team working approach across the sites, both MSESr and the panel recognised the inherent cultural challenge in bringing together teams from across different sites with differing organisational cultures.
- 8.4 There had been little information on workforce numbers or capacity which had made it difficult to assess the degree of impact of the proposals.
- 8.5 The panel agreed that in order to inform and support pathway development there needed to be more robust data on volumes, clarity on whether the cases would be split by acuity or speciality and workforce data.



8.6 The panel was concerned regarding workforce plans; it was not certain whether the same teams might be providing elective work on one site and emergency cover on another. There were also concerns that, whilst supportive of consolidating services to improve quality and build sustainable services, the volumes might be such that two teams could potentially be required to cover some specialities on the high volume site(s).

8.7 RECOMMENDATIONS

RECOMMENDATION 25

8.7.1 The team had recognised the need for community support and the panel recommended the team needed to work up the detail, protocols and pathways to support elective patient's return to community settings at the earliest opportunity to inform the overall model.

RECOMMENDATION 26

8.7.2 The panel recommended the team should also work up the detail around the identified inter-dependencies and undertake detailed modelling regarding any options to potentially be taken forward.

RECOMMENDATION 27

8.7.3 The panel recommended that detailed workforce modelling be undertaken. This should include staffing to support emergency rotas and to support elective work, including the detail around workforce.

END



APPENDIX 1: Terms of Reference for the review

**East of England Clinical Senate
Independent clinical review panel for
Mid and South Essex Success Regime
14 June 2016**

Terms of Reference



CLINICAL REVIEW: TERMS OF REFERENCE

Title: **Proposals for the acute model and associated services**

Sponsoring Organisation: **Mid and South Essex Success Regime**

Clinical Senate: **East of England**

NHS England sub regional: **East**

Terms of reference agreed by:

Dr Bernard Brett on behalf of East of England Clinical Senate and



Dr Ronan Fenton on behalf of Mid and South Essex Success Regime.



Date: 24 May 2016



Clinical Review Team Members

Dr Bernard Brett	Chairman of Review Panel Chair East of England Clinical Senate Council
Dr Jennifer Birch	Consultant in Neonatal medicine Luton & Dunstable Hospital
Erica Crust	Paediatrics Sister Nottingham
Dr Robert Florance	Consultant Emergency medicine Queen Elizabeth Hospital, King's Lynn
Claire French	Patient representative
Dr David R Gaunt	Unplanned Care Consultant & Associate MD Watford Hospital
Rachel Hulse	Service Manager and Lead AHP Emergency Division, James Paget Hospital
Dr Dayo Kuku	GP and CCG Clinical Lead Bedfordshire CCG Clinical Lead
Dr Harriet Nicholls	Consultant Obstetric Anaesthetist Luton & Dunstable Hospital
Nadim Noor	Vascular Surgeon Bedford
Sarah Rattigan	Neonatal ODN Director East of England (Approved by Ronan Fenton)
Caroline Smith	Patient representative
Ann Walker	Clinical Midwifery Manager NNUH



Aims and objectives of the clinical review

The clinical senate is asked to advise whether

In the context of the case for change and national recommendations for care models, do the proposed "options" for the reconfiguration of services between Mid Essex Hospital Trust, Southend University Hospital Foundation Trust and Basildon and Thurrock Universities Hospital Foundation Trust constitute reasonable proposals to improve clinical outcomes, ensure a sustainable workforce and improve efficiency and productivity?

Scope of the review

The clinical senate review panel is asked to review the available evidence and make recommendations. Documents will include

- **Diagnostic materials**
- **Summary of options with supporting evidence**

Key questions to answer include:

Do the ideas make clinical sense given the health need, health service need and clinical standards / evidence?

Are there other impacts that should be assessed or other unintended consequences that have not been mentioned?

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

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

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England assurance process that will be reviewed elsewhere (e.g.



financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

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

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

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

Timeline

The review panel will be held on the 14 June 2016.



Reporting arrangements

The clinical review team will report to the clinical senate council which will ensure the report meets 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 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 to ensure it has met the agreed terms of reference and to agree the report.

The final report will be submitted to the Mid and South Essex Success Regime by **14 July 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 data (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.



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



APPENDIX 2: Membership of the review panel

Chairman of review panel:

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:

Dr Jennifer Birch

**Consultant in Neonatal Medicine and Neonatal Clinical Director
Luton and Dunstable University Hospital**

Dr Jennifer Birch has been Neonatal Unit Clinical Director for almost 3 years at the Luton and Dunstable University Hospital Foundation Trust where she has worked as a Consultant in Neonatal Medicine since early 2009. Her clinical special interests include nutrition and neonatal gastrointestinal conditions such as NEC. Other interests include clinical governance, risk management and quality improvement. She has recently been the East of England Senate representative for the Neonatal Critical Care CRG and is currently working towards a Masters degree in NHS Leadership.

Revd. Erica Crust Paediatric Sister

Paediatric Rheumatology Nurse at Peterborough and Stamford NHS Trust.

Manage/lead the Rainforest Children's Outpatient and Nurse led Unit and is the Paediatric Rheumatology Nurse at Peterborough and Stamford NHS Trust. (shared care with Queens Medical Centre Nottingham) . Working on a 2 year CQUIN project for the transition of Children and Young People into Adult Services.

Previous experience includes the Paediatric acute assessment unit, Paediatric day surgery and Paediatric Inpatient services. Adult Accident and Emergency Dept., Geriatrics and Adult Renal Transplant and Dialysis.

Dr Robert Florance

Consultant in Emergency Medicine, Queen Elizabeth Hospital Kings Lynn

Senate assembly member.



Claire French

Patient representative

Worked with the NHS, locally, regionally and nationally as an expert patient for fifteen years. Also the experiential knowledge that has been gained as a patient with a hereditary neurological condition is invaluable to these roles. Successfully gained a Health and Social studies degree and Disability Equality practitioner post graduate certificate.

Currently, involved with NHS Citizen and as the East of England Clinical Networks co-chair for Mental Health, Dementia, Neurological Conditions, Learning Disability and Autism steering group; and chairs her General Practice Patient Participation Group.

Dr David Gaunt

Consultant, Emergency Medicine

West Herts Hospitals NHS Trust

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

Rachel Hulse

Service Manager and Lead Allied Health Professional - Emergency Division

James Paget University Hospitals NHS Foundation Trust

Working as a Service Manager and Lead Allied Health Professional at the James Paget University Hospitals NHS Foundation Trust. Qualified as a Radiographer in 1992, specialising in Ultrasound and gaining an MSc in Medical Imaging Science (Ultrasound). Following work for the Cancer Services Collaborative and Emergency Services Collaborative, moved into general management with a particular emphasis on Allied Health Professionals.

Dr Adedayo (Dayo) Kuku

Respiratory Clinical Lead GP

Bedfordshire CCG

MBBS, DFFP, MRCP

Respiratory Clinical Lead GP Bedfordshire Clinical Commissioning Group and Chair of Bedoc.

A practising GP with keen interest in respiratory medicine, who qualified in 1987. She was appointed as Respiratory Clinical Lead GP for Bedfordshire Clinical Commissioning Group (BCCG) in 2013 and currently chairs the local Respiratory Implementation Group promoting and facilitating the delivery of improved respiratory care for the people of Bedfordshire.

Dayo was appointed Chair of Council Bedoc (Out of Hours service) in April 2014, she also sits on the Bedfordshire and Luton Joint Prescribing Committee (JPC) .



Dr Harriet Nicholls
Consultant Anaesthetist
Luton & Dunstable Hospital

Dr Harriet Nicholls is a consultant obstetric anaesthetist, has led multi-disciplinary Human Factors cultural change programmes and is a qualified and practising executive coach and mentor. Harriet is an associate medical director of medical leadership and development at the Luton and Dunstable NHS FT.

Nadim Noor
Consultant Vascular and Endovascular Surgeon (Clinical Lead)
Bedford Hospital NHS Trust and Luton and Dunstable Hospital NHS FT

A consultant vascular and endovascular surgeon, with a keen interest in healthcare management with a view to improve quality and patient experience

Sarah Rattigan
Neonatal ODN Director, East of England

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.

Caroline Smith
Patient representative

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

Ann Walker
Clinical Midwifery Manager/Matron Delivery Suite
Norfolk and Norwich University Hospital

A midwife since qualifying in 1988. Spent many years as a community midwife and completed a diploma and then a BSC in Advanced Midwifery Practice. Successful in being appointed to her first midwifery manager post in 2010 and spent 5 years at the James Paget University Hospital NHS Foundation Trust where she is responsible for the inpatient maternity services. Has undertaken a Leadership and Management Level 5 award with the Institute of Leadership and Management, followed by achieving a Master's degree with distinction in Leading innovation for Clinical Practitioners at the UEA. Matron for the delivery suite at the Norfolk & Norwich University Hospital NHS Foundation Trust since March 2015, and holds an Associate Lectureship post at the UEA.



In attendance at the panel:

Mid & South Essex Success Regime:

Ben Horner, Principal, Boston Consulting Group

Dr Celia Skinner, Medical Director, Basildon & Thurrock University Hospital Trust

Dr Donald McGeachy, Medical Director, Mid Essex CCG

Clinical Senate Support Team:

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

Brenda Allen, Senate Project Officer, East of England Clinical Senate, NHS England

Sarah Steele, Quality Improvement Manager, East of England Clinical Networks, NHS England



APPENDIX 3: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Bernard Brett	None	None	None	None
Jennifer Birch	None	None	None	None
Erica Crust	None	None	None	None
Robert Florance	None	None	None	None
Claire French	None	None	None	None
David R Gaunt	None	None	None	None
Rachel Hulse	None	None	None	None
Dayo Kuku	None	None	None	None
Harriet Nicholls	None	None	None	None
Nadim Noor	None	None	None	None
Sarah Rattigan *	None	None	None	None
Caroline Smith	None	None	None	None
Ann Walker	None	None	None	None

***Sarah Rattigan:** prior to the panel, declared that her regional role as Neonatal Operational Delivery Network Director included the Essex area.

Dr Ronan Fenton confirmed that this would have no influence or impact on the matter and Sarah Rattigan could remain on the panel.



APPENDIX 4: Key lines of enquiry

INDEPENDENT CLINICAL REVIEW PANEL

Sponsoring body: Mid & South Essex Success Regime

AGENDA

Date: Tuesday 14 June 2016

Time: Panel members 09.30hrs to 16.30hrs &

Mid & South Essex Success Regime members 10.15hrs to 14.40hrs

Venue: British Racing School, Snailwell Road, Newmarket, CB8 7NU

The panel is being asked to consider:

“In the context of the case for change and national recommendations for care models, do the proposed ‘options’ for the reconfiguration of services between Mid Essex Hospital Trust, Southend University Hospital Foundation Trust and Basildon and Thurrock Universities Hospital Foundation Trust constitute reasonable proposals to improve clinical outcomes, ensure a sustainable workforce and improve efficiency and productivity?”



Time	Item
09.30 -10.15	Panel member briefing
10.20 –10.35	Welcome, introductions and outline of panel procedure by Clinical Review Panel Chairman Dr Bernard Brett
10.35 - 11.00 25 mins	Presentation and context setting for the panel from the Essex Success Regime members (sponsoring body)
11.00 – 12.00 60 mins	<p>Questions from the panel to Essex Success Regime General enquiries and key lines of enquiry for ‘Urgent & emergency care’</p> <p>The panel would like to hear more about the options for urgent and emergency care, including</p> <ul style="list-style-type: none"> - Pathways and triage for patients, in particular management (transfer) of patients that require treatment elsewhere, arrangements for diagnostics and imaging services, rapid access to specialists on other sites - Arrangements for transfer / repatriation of patients including transfer support teams and transport and managing the impact on the ambulance service - Current and future capacity of critical care including the support arrangements and including residual cover in units with fewer or no ICU beds - Ensuring patients e.g. terminal cancer patients, requiring urgent or emergency care access the appropriate services / location at the first point of entry - Which emergency services will be provided on which sites – do they link in with the elective proposals? <p>Areas of general enquiry</p> <p>Are there plans to undertake modelling to ensure the appropriate balance between quality of services and reduction in unplanned admissions (or emergency bed days?).</p> <p>Workforce – how will they ensure that the chosen options will not lead to difficulties with the recruitment, retention and training of the workforce? – for example the impact of working in a centre of excellence or in another hospital and the impact of elective work on one site and emergency work on another.</p> <p>Recognising the national issues around health workforce, could the Essex Success Regime team provide some information on how it intends to ensure the new integrated system will be appropriately staffed and skilled to provide safe, quality care for patients?</p> <p>How closer working between different providers will be delivered (eg health, social care, third sector etc)</p> <p>How will the Success Regime ensure that there is clarity for the general public, patients and staff regarding terminology and which services are provided at which unit? How can they ensure that the system is easy to</p>



	<p>navigate?</p> <p>The panel recognise that the enablers including clinical IT systems are to be developed further down the line, but would seek some assurance that they will be included as a critical part of patient pathways</p> <p>The panel wishes to understand how the Essex Success Regime in linking in with work in the rest of Essex and with other surrounding providers involved in current or potential future patient pathways such as the London Hospitals, Addenbrookes and Luton and Dunstable.</p>
12.00 – 12.30 30 mins	<p>Questions from the panel to Essex Success Regime Key line of enquiry for Women’s (services)</p> <p>The panel is keen to understand</p> <ul style="list-style-type: none"> - Whether there has been any modelling on / discussions on pathways and / or about the impact of the proposals / patient flow for tertiary care on adjoining health systems and neighbouring Trusts, i.e. Royal London, Homerton and Addenbrookes. - *Neonatal units require the support of Paediatricians, so some clarification of options for other paediatric services which cross over - Consideration of the viability of a SCBU with midwifery led unit but no Obstetrician unit (Option 2 Site C p132) - Arrangements for the link between paediatrics, high risk deliveries and support for SCBU - The impact of staff recruitment and retention if the service is split. - Data on day case and in patient cases and elective and emergency gynaecology activity. - Access to cancer care for gynaecology patients <p>*using terminology applied in the evidence – clarity regarding neonatal units</p>
12.30 10 mins	Urgent and emergency care and Women’s services - closing comments from Essex Success Regime
12.40	Summary from Panel chair
12.55 – 13.15	Short break for lunch
13.20 -13.50 30 mins	<p>Questions from the panel to Essex Success Regime</p> <p>Key line of enquiry for ‘Paediatrics’</p> <p>The panel would like to hear more on</p> <ul style="list-style-type: none"> - Clarification on meaning of “if required” for paediatric elective surgery & NICU (p151 Site C options 1 & 2) - Clarification of “elective” activity p142, i.e. numbers and does this include medical activity. Details on paediatric surgery Do the options include medical inpatients on every site? - PAU model noted to be 8am-11pm, how will neonatal unit be supported outside of those hours. Will all PAU have short stay and if so presumably this will still require 24/7 paediatrician cover?



13.50 -14.10 20 mins	<p>Questions from the panel to Essex Success Regime</p> <p>Key line of enquiry for 'Elective surgery'</p> <p>The panel would like to hear more detail on the options for elective surgery including the case for change for separating elective from acute services.</p> <p>Has accepting some of the givens restricted the possible options? Can you assure that staff covering inpatient elective work aren't also covering emergency work on another site?</p>
14.10	Paediatrics and Elective surgery: closing comments from Essex Success Regime
14.20	Paediatrics and Elective surgery: Summary from Review Panel chair
14.35	Essex Success Regime members depart. Short break for panel members
14.50 – 16.10	Discussion - panel members only.
16.10 – 16.25	Summary of recommendations Close.



APPENDIX 5: Summary of documents provided by Mid and South Essex Success Regime as evidence to the panel

1. Submission for Clinical Senate Panel document 1 June 2016 (183 pages)
2. Presentation to panel, 14 June 2016

