West Midlands Clinical Senate

Future of Acute Hospital Services in Worcestershire - **Stage 2 Clinical Assurance Review Panel Final Report**

Future of Acute Hospital Services in Worcestershire – Stage 2 Clinical Assurance Panel Report

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Contents

Foreword by: Panel Chair, Dr Helen Carter

Worcestershire, like many other health economies across the country, is having to transform whilst continuing to provide care to meet the increasing needs and demands of the local population. The case for change has been well made elsewhere and this report does not intend to duplicate or re-visit this.

The first Senate review Panel that I chaired in 2015 supported the recommendation from the 2014 Independent Clinical Review Panel that some form of Emergency Department provision was required to remain at the Alexandra Hospital site and this position remains unchanged. The detail of the previous model reviewed in 2015 highlighted concerns specifically relating to: patient safety risks, staffing levels, public behaviours, care of paediatric emergencies and the lack of frontline clinical support for the model.

The Panel would like to acknowledge that a significant amount of change has occurred in the last ten months since the first review in terms of changes to senior personnel and the movement of some services from the Alexandra Hospital site to the Worcestershire Royal Hospital site due to patient safety thresholds being exceeded.

I would like to commend this health economy in terms of the progress that has been made since our first Panel assurance review in 2015. Tremendous efforts have been made to address the previous deficiencies in clinical engagement. The Panel accepts that not everyone will agree with the proposals but there has been a large shift in culture within this Provider and across the wider health economy. My 'ask' as chair of the Panel during this second review was to try to determine of the clinicians who did not support the proposed changes and whether this was because they had concerns regarding patient safety or was their lack of support due to other reasons. This was often a difficult task to undertake. Where potential patient safety concerns were raised we developed key lines of enquiry and sought additional assurance from the Programme Board to address these. We would like to thank all of the staff that we met during our site visit and again commend them for their candour and courage in speaking out and voicing their views and opinions.

We would like also to acknowledge the impact that the uncertainty of the future configuration of these hospitals is having upon staff morale, recruitment and retention. We hope that this report, alongside the future Sustainability and Transformation Plans, will provide some clarity and certainty to staff.

The Panel identified many questions outside of the scope of the terms of reference for this review. We agreed to include these within an appendix so that although the Panel is not making any recommendations based upon these discussions, their inclusion gives an indication of the amount of detail and challenge that was covered during this second review.

Finally, I would like to thank the Panel members for their contributions to this review. Many Panel members travelled considerable distances from outside of the West Midlands to participate and support this review. Where they were unable to join the discussions in person, they still dedicated significant amounts of time to reviewing

documents, developing key lines of enquiry and contributing to the development of the recommendations and advice.

1 Senate Chair Summary and Recommendations – Dr David Hegarty

Commissioners and providers across many health economies are faced with ever increasing demands for health care and wide ranging challenges with respect to the most appropriate delivery and location of service provision. As a result of these ever increasing complexities of health care delivery, many health economies are undertaking large scale reviews of the health care services they currently provide and how they might be better optimised within an ever challenging financial envelope. The need to re-configure service provision is often seen as the most appropriate way forward and this very same set of challenges is ever present within the Worcestershire Health Economy.

Faced with these significant set of challenging scenarios the West Midlands Clinical Senate was asked by the NHS England Arden, Herefordshire and Worcestershire Area Team in 2015 to undertake a Stage 2 Clinical Assurance Review of the Summary Model of Care, which had been developed through the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme. Assurance was sought to assess the clinical quality, safety and sustainability of the proposed model of care. The findings of this first review did not support some aspects of the proposed clinical model and the health economy has been working to address this and requested a second Panel review in February 2016. This second review focused upon the main recommendations made from the first review and was requested by the sponsoring organisations of NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG, on behalf of the FoAHSW Programme Board.

The Panel of external clinical experts that was established to undertake this additional review, wherever possible, included many of the members that took part in the first review to provide some consistency and “memory” within the process. During the three panel review days much documentary, PowerPoint and verbal evidence was presented to the Panel, and discussions were held with a number of key stakeholders in order to allow the Panel to consider the clinical model against the key criteria, including the need to provide high-quality, safe and sustainable care for the population of Worcestershire, both now and in the future. Day two was spent visiting both sites at the Alexandra Hospital (AH) in Redditch and the Worcestershire Royal Hospital (WRH) and was found to be very beneficial for the panel in preparation for day three.

It is extremely encouraging to hear about the very significant progress that has been made by this health economy since the last review was undertaken. Great strides have been evidenced with respect to clinical engagement and buy-in to the proposed model across much of the clinical community. Whilst it is always difficult to gain full support from all staff it is assuring to see staff from both hospital sites embracing the proposed changes and the efforts from both the management team and clinical teams and their level of commitment to the safe care of patients as exemplified by

the relocation of some services from the Alexandra site to the Worcestershire Royal Site on the basis of recent patient safety thresholds.

I would like to thank the Panel members for their expertise and insight in undertaking the review and their many and varied contributions either in person or remotely and of course to the final report. I would like to thank the various organisations, including the Trust, commissioners and other members of the FoAHSW Programme Board and, in particular, I would like to thank the individual clinicians and managers who contributed to this formal assurance process.

1.1 Summary

The West Midlands Clinical Senate was asked by the NHS England Arden, Herefordshire and Worcestershire Area Team in 2015 to undertake a Stage 2 Clinical Assurance Review of the Summary Model of Care, which had been developed through the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme, prior to public consultation. This first review did not support some aspects of the proposed clinical model and the health economy has been working to address this and requested a second Panel review in February 2016. This second review focuses upon the main recommendations made from the first review and was requested by the sponsoring organisations (NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG), on behalf of the FoAHSW Programme Board.

The West Midlands Clinical Senate established a Panel of external clinical experts to review the proposed clinical model, many of whom had been members of the first panel review to provide some consistency with the process. Three panel review days were held between April 2016 and May 2016. Documentary, PowerPoint and verbal evidence was presented to the Panel, and discussions were held with a number of key stakeholders in order to allow the Panel to consider the clinical model against a number of key criteria, including the need to provide high-quality, safe and sustainable care for the population of Worcestershire, both now and in the future. Day two was spent visiting both sites at the Alexandra Hospital (AH) in Redditch and the Worcestershire Royal Hospital (WRH).

The Panel was asked to make recommendations to the West Midlands Clinical Senate on whether to support the evolved model.

These recommendations are summarised below.

1.2 Recommendations

Recommendation from June 2015 first Panel review	Summary of recommendation from second Panel review May 2016
The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	The Panel concluded this recommendation has been addressed. The evidence presented included the current activity modelling, development of a consultant-led paediatric assessment unit at the WRH site to improve triage, assessment and observation and to reduce length of stay with increasing the provision of care in the community
The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety	The Panel concluded that this recommendation has been met. The Panel now approves the model of emergency care for the AH site based upon the evidence presented including greater clarity of vision regarding the practicalities of the model, the proposed staffing levels and skill mix and frontline clinical support for the model. The Panel made recommendations regarding future Consultant workforce levels and the need for clarity regarding the difference between the Emergency Medicine Department and the co-located Urgent Care Centre specifically with respect to paediatrics
The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	The Panel concluded that this recommendation has been addressed and was appropriate for this stage of development of the model. Even so, the Panel continued to have concerns regarding public behaviour that it believed would need to be addressed during the wider consultation and public engagement phases of development.
The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.	The Panel conclude that this recommendation has been addressed. Outside of the ToR relating to the model of Emergency Medicine provision at the AH, the Panel heard evidence from the acute medical consultants at the AH and recommends that further engagement work is done with this group to address their patient safety concerns.

2 Background

2.1 Geographical Background

There are three Clinical Commissioning Groups (CCGs) within Worcestershire, reflecting the natural, geographic communities across Wyre Forest, Redditch and Bromsgrove, and South Worcestershire. Acute hospital services are provided by the Worcestershire Acute Hospitals NHS Trust (WAHT) at Worcestershire Royal Hospital (WRH), the Alexandra Hospital (AH) in Redditch, and Kidderminster Hospital and Treatment Centre (KHTC). In addition, Worcestershire Health and Care NHS Trust provide four community hospitals with Minor Injuries Units (MIUs).

WAHT provides a wide range of services to a population of more than 550,000 within Worcestershire (WAHT 2015). In addition, WAHT also provides services for residents of South Birmingham, Warwickshire, Shropshire, Herefordshire and Gloucestershire.

2.2 Scope and Limitations of Review

This is the second stage 2 assurance review that has been conducted by the West Midlands Clinical Senate on this health economy and this report should be read in conjunction with the first Panel review from June 2015:

http://www.wmscnsenate.nhs.uk/files/8414/3402/0262/WMCS_Final_The_Future_of_Acute_Hospital_Services_in_Worcestershire_Review_-_Version_4.0.pdf

The terms of reference (ToR) were refined to focus upon the main recommendations made during the first Panel review.

The decision was taken deliberately not to undertake this as solely a table top review. The site visit on day 2 was retained so that the Panel could hear directly the views of frontline staff regarding their views of the proposed model.

2.3 Limitations

To meet the challenging timescales it was noted in advance that the site visit was on the day after a Bank Holiday and that during the previous week the junior doctors had been on strike for 2 days and thus the activity levels in the Emergency Departments may not have reflected usual increased levels of activity.

No further specific limitations relating to the review were identified beyond its original terms of reference.

3 Methodology of the Review

The role of the Panel was to examine a significant amount of documentary evidence in advance of the first day, develop key lines of enquiry and discuss these with representatives from the health economy: Provider, Programme Board, Healthwatch and CCGs. The Panel was tasked to explore and challenge the proposed model from its respective areas of clinical expertise and then reach a consensus, draw conclusions and make recommendations. Where clinical guidance exists, this

informed the discussions and, where this was not available, a clinical opinion was given, thus adopting an evidenced based approach wherever possible.

The West Midlands Clinical Senate acknowledges that the sponsoring organisations (NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG), have undergone a first and second stage assurance review as a component of the NHS England assurance process and is now ready to undertake a second 2(b) stage assurance external expert review as part of the FoAHSW review programme (see **Appendix 1:4** NHS England Assurance process).

The 2(b) assurance review will be carried out in line with the key tests and an appropriate selection of best practice checks as a component of the NHS England final assurance process.

3.1 Terms of Reference

The ToR for this review were developed in partnership between the Senate and the FoAHSW Programme Board and reflected the main recommendations made following on from the first Senate Panel review held in June 2015.

In summary the ToR were for the Panel to re-assess the clinical quality, safety and sustainability of the redeveloped Summary Model for Emergency Care, against the recommendations made in the final report of the West Midlands Clinical Senate review, published on 11th June 2015, and to ensure that the suggested changes would not compromise interdependencies with other parts of the model which have already been successfully reviewed.

It was acknowledged that some temporary emergency changes to the current clinical model had been undertaken since June 2015 due to clinical patient safety triggers having been breached. These were made explicit to the Panel prior to day 1, for example the relocation of neonatal and obstetric services from the Alexandra Hospital site to the Worcestershire Royal site.

The Panel was required to assess the clinical quality, safety and sustainability of the clinical model(s) prior to public consultation. The Terms of Reference for the review were developed as per NHS England guidance (see **Appendix 1:4**).

3.2 Objectives

The Independent Clinical Review Panel will:

a) Review and re-assess the redeveloped clinical model for Emergency Care against the recommended criteria set out in the FINAL report of the West Midlands Clinical Senate review, June 2015 (full recommendations are available in **Appendix 1:3**):

Recommendation number	Recommendations from FINAL report of WMCS (June 2015)	
1: Obstetrics and Gynaecology and Emergency Surgery	The Panel supports the proposals set out within the Summary Model of Care to reconfigure the Obstetrics and Gynaecology and Emergency Surgery services through transferring these from Alexandra Hospital and Consolidating them onto the Worcestershire Royal Hospital site.	Recommendation previously supported by the West Midlands Clinical Senate (WMCS) and therefore this element of the model is out with the scope of this WMCS review.
2: Inpatient Paediatrics	The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	This would need to include: 1. A clear plan and risk assessment of the likely shortfall of paediatric nursing recruitment at the WRH site 2. The expansion of car Parking / park and ride provision at WRH to cope with the increased Demands of those travelling by car from Redditch and Bromsgrove.
3: Urgent Medical Care	The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety	These concerns relate to issues of: 1. Sustainable staffing, with a national shortage of Emergency Department (ED) Consultants, middle grades and the potential for trainees to be removed from the AH site 2. Public and staff misunderstanding of the model of Emergency Medical Care at AH (see also Recommendation 4, below) 3. Increased clinical risk arising from the removal of key services from AH aligned to the management of emergency care, including Inpatient Paediatrics and Emergency Surgery - and their further critical interdependencies with other clinical specialties, including Anaesthetics and Critical Care.

4: Urgent Medical Care for Children at AH	The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	This should include: 1. Making absolutely explicit the extent and remit of urgent/emergency paediatric cover 2. Having a clear plan for dealing with paediatric emergency presentations at AH out of hours 3. Undertaking a full risk assessment in respect of any proposals for paediatric emergency provision that are less than 24/7 4. A detailed consideration of how seriously unwell children presenting at the AH site, who do not meet critical care transport team criteria, will be safely transferred to the WRH site. This should encompass personnel, equipment and transport logistics.
5: Engagement and Co-ownership from Frontline Clinical Workforce	The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.	

b) Consider the final clinical model for Emergency Care prior to public consultation against the above criteria and make recommendations on whether to support the model to the West Midlands Clinical Senate Council and thereafter to the FoAHSW Programme Board and sponsoring organisations.

3.3 Process

The West Midlands Clinical Senate collated advice between February-April 2016, assisted by an Independent Clinical Review Team (known as the Panel within this report). This Panel included members from professional groups with specific knowledge and expertise in those areas on which the Clinical Senate had been asked to provide advice. To ensure any advice given was robust, transparent and credible. The Panel included clinical experts from outside the West Midlands area where possible (see **Table 1** and **Appendix 1**).

It was agreed with the FoAHSW Programme Board that, in order to provide some continuity in the review process, it would be beneficial to try to use as many of the Panel members from the first Panel in 2015 for this review. Where this was not

possible, new Panel members were recruited from across the country and these new Panel members had pre-review briefings with the Panel chair in advance of day 1.

A confidentiality agreement was signed by all Panel members and any potential conflicts and associations were declared during the process. These are recorded in **Appendix 1:2**.

Panel review dates were held on 21st April, 3rd May and 16th May 2016 (see **Appendices 4-6**). The Panel reviewed documentation provided by the FoAHSW Programme Board and heard presentations from individual members of the FoAHSW Programme Board and key stakeholders including Healthwatch. During Day 2 of the Review, on 3rd May 2016, Panel members undertook site visits to WRH and AH, touring relevant clinical areas.

Where Panel members were unable to attend in person, they reviewed all of the documentation remotely and submitted questions and these were then addressed by the FoAHSW Programme Board.

Table 1

Independent Clinical Review Team

Name	Position	Organisation
Dr Helen Carter Chair	Deputy Director of Healthcare Public Health and Workforce	Public Health England, West Midlands
Prof Guy Daly Vice Chair	Executive Dean of the Faculty of Health and Life Sciences	Coventry University

Members:

Name	Position	Organisation
Dr Rashid Sohail	Deputy Medical Director	East Midlands Ambulance Service
Mr Keith Spurr	Patient and Public Representative	East Midlands Strategic Clinical Network and Senate
Dr Peter Marc -Fortune	Consultant Paediatric Intensivist	Central Manchester University Hospital
Prof Ian Greaves	Professor in Emergency Medicine	South Tees Hospitals NHS Foundation Trust
Mr Athur Harikrishnan	General and Colorectal Surgeon	Sheffield Teaching Hospital NHS Foundation Trust
Prof Edward Davis	Orthopaedic Surgeon	The Royal Orthopaedic Hospital, Birmingham
Dr Helen Hurst	Advanced Nurse Practitioner	Manchester Royal Infirmary
Dr Andrew Phillips	General Practitioner	NHS Vale of York CCG

Mr Peter Sedman	General Surgeon	Hull Royal infirmary
Mr Duncan Learmonth	Orthopaedic Surgeon	The Priory Birmingham
Dr Jackie McLennan	Senior Emergency Medicine Consultant	Manchester
Dr Richard Elliott	Consultant Anaesthetist	Royal Derby Hospital
In attendance		
Rob Wilson	Interim Associate Director	West Midlands SCN and Clinical Senate
Kate Burley	Network Manager	West Midlands SCN and Clinical Senate
Karen Edwards	Clinical Senate PA	West Midlands SCN and Clinical Senate
Rachel Knowles	Clinical Senate Admin Support	West Midlands SCN and Clinical Senate

4 Description of Current Service Model

WAHT provides a wide range of services to a population of more than 550,000 within Worcestershire. Patients are also served from neighbouring areas including: South Birmingham, Warwickshire, Shropshire, Herefordshire and Gloucestershire.

WAHT currently provides services from three main hospital sites:

- Alexandra Hospital (AH) in Redditch;
- Kidderminster Hospital and Treatment Centre (KHTC) in Kidderminster; and
- Worcestershire Royal Hospital (WRH).

In light of its performance challenges, national planning requirements and local commissioning intentions, WAHT recognised the need to 'develop and sustain business as a key strategic priority within its 2013/14 Annual Plan and this remains a current strategic goal within the Trust's Integrated Business Plan 2014/15 – 2018/19. This objective served to focus the Trust on meeting the growing demand for its services while securing a long-term clinical services strategy for the delivery of acute care across its hospital sites. The Trust's Clinical Services Strategy is aimed at supporting the delivery of high-quality care across its services, securing increased levels of efficiency through service redesign, better working practices and the application of best clinical evidence.

The need for change from the current model of care provided by WAHT was highlighted in the strategic themes that emerged from the Clinical Services Strategy. Clinicians at the Trust focused on the need to configure acute services at WAHT in such a way as to:

- Deliver consistently high-quality, safe services
- Overcome medical and nursing workforce challenges in delivering 24/7 specialist care
- Ensure services have the right capacity to meet future demand

- Improve clinical productivity and effectiveness
- Ensure critical clinical adjacencies are secured
- Establish a clinical configuration of services that supports other key strategic initiatives of the trust

In 2015 WRH and AH provided a full range of general and acute hospital services as well as some tertiary services, with Kidderminster offering a 24-hour nurse-led treatment centre and a full range of diagnostic, day-case surgery and ambulatory services.

This Provider Trust was placed into Special measures in December 2015. As a result of this there has been a significant change in senior management and additional external expert support including buddying arrangements to support them to stabilise their current levels of service provision.

During 2015-2016 due to pre-identified patient safety triggers being breached there have been some changes to the current model of service provision between the 2 hospital sites as summarised below:

- neonatal and obstetric services were moved from the AH to the WRH site
- elective abdominal surgery moved from the WRH to the AH site
- the majority of cold elective orthopaedic surgery is moving from the WRH to the AH
- the Clinical Navigation unit at the AH had closed in March 2016 as a result of a commissioning decision

Additionally, Worcestershire Health and Care NHS Trust operates some services from four local community hospitals: Princess of Wales Community Hospital in Bromsgrove, Tenbury Community Hospital, Evesham Community Hospital and Malvern Community Hospital. The services provided at these community hospitals did not form part of the Stage 2 assurance review process.

5 The Case for Change

5.1 The Case for Change

The Worcestershire health economy has been facing the same challenges as many health economies across the country and it has been recognised that there is a need to make some changes in the way that services are delivered to ensure that services are safe and sustainable in the future. This existing work will dovetail into the future Sustainability and Transformation Plans for Herefordshire and Worcestershire that will attempt to redress the triple aim of reducing the gaps for: quality, finances and health and wellbeing.

Similar to the first Panel review in 2015 it was necessary to highlight the process that led to the development of the original 13 options, the subsequent development of the two options that had been presented for review by the ICRP, and the final development of the modified version of Option 1, which the West Midlands Clinical Senate has been tasked to review.

Worcestershire clinicians developed the Case for Change (2014) with involvement from providers, commissioners (initially NHS Worcestershire and, subsequently, the three Worcestershire CCGs), representatives of patient groups and the public as a result of safety concerns relating to a number of services within Worcestershire Acute Hospitals Trust (WAHT). It built upon the Case for Change (2012) set out in the Joint Services Review (JSR) established in January 2012 and that ran until April 2013. It was updated to include the information that has become available since the JSR was replaced by the FoAHSW programme in September 2013, as well as taking into account the recommendations of the Independent Clinical Review Panel, which reported in January 2014.

The detail outlining the case for change for specific specialities (surgery and orthopaedics, emergency care, obstetrics and paediatrics) was described fully in the first Panel review published in 2015 and will not be replicated in this document.
The Panel was of the view that a clear and compelling case for change had already been made, based on sound evidence presented to it on current performance, improvements seen in other regions by reconfiguration of services within multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy.

Since the first Panel review in 2015 significant progress has been made by this health economy in terms of progressing the vision, detail and clinical engagement for the future models of emergency care at the AH. Two main task and finish groups (Urgent Care and Women and Children) were established with external, senior and experienced chairs. There has also been greater clinical ownership of developing new models as evidenced by the anaesthetists and the maternity and paediatric divisions.

The Panel noted in advance of the review commencing that the proposed future model of care had been approved by all 3 CCG Governing bodies.

6 Summary of Day 1

At the start of this second review the Panel was reminded by the chair of the agreed Terms of Reference. The Panel was specifically asked to review:

- Inpatient paediatrics-including the plans for managing additional capacity at the Worcestershire Royal site when paediatric inpatient moves there from the AH site
- To explore in detail the proposed model of urgent medical care at the Alexandra Hospital site and specifically the care of paediatric patients and the level of frontline clinical support for the model
- To explore the level of clinical engagement and co-ownership

The Panel was briefed upon the key changes that had taken place since the first review including the changes in a significant number of senior staff and the re-location of maternity services from the Alexandra Hospital site to the Worcestershire Royal site due to patient safety triggers having been breached.

The chair tasked the Panel to consider what level of evidence they would like to review to be provided with assurance that the proposed model was safe and in

addition where there was not frontline clinical support to ask questions to understand the reasons for this.

Following the review of the evidence and from the pre-meeting, the following key lines of enquiry were developed by the Panel:

- Clinical support for the model: the Panel was impressed with the level of transparency of the evidence provided to it including the summary of all of the individual comments made by frontline staff during engagement events. The Panel specifically wanted to explore further nursing and allied health professional staff engagement and support. Also the Panel requested more detail regarding the concerns that were being articulated by the acute medical consultants from the Alexandra Hospital site although accepted this would be addressed during the site visit on day 2
- Patient and public behaviours-what lessons had been learnt following the movement of maternity services from the Alexandra Hospital to the Worcestershire Royal site? Does this have any implications for the proposed future model?
- What progress had been made on the transport links between sites for public and staff? A transport impact assessment had been undertaken but it was requested that there was further exploration of this
- To explore further the symbiotic relationship between the two hospital sites and explore further what county wide working may look like in practice
- What is the capacity at the Worcestershire Royal site: both in terms of the ED department and the implications from the new model at the Alexandra site but also inpatient paediatrics
- Transport: explore if any changes had been identified regarding the impacts for West Midlands Ambulance Service (WMAS)- it was noted that during the first Panel review WMAS has presented on the impacts of the service configuration changes on their capacity and WMAS presentation was sent to panel after Day 1 following questions from the panel
- Health Education England support for the model and the placement implications for future junior doctors
- Explore in detail what the model at the Alexandra Hospital is going to be in terms of: the Emergency Medicine Department, staffing levels, skill mix, care of paediatrics and the co-located Urgent Care Centre model.

The Panel heard evidence from a range of individuals representing: the Programme Board, CCGs, Healthwatch Worcestershire, Executives and Divisional Directors from the Provider and key clinicians. The Panel was impressed by the openness and honesty of the Provider and the acceptance that mistakes had been made in developing the first model and much learning had been identified from this.

There was a much greater consensus and clarity of vision regarding the detail of the proposed model for the Emergency Medicine at the Alexandra Hospital site. The Panel supported the proposal that this should be a 16+ only ED department and accepted that mitigations had been developed should a critically ill child be brought in by their carers through having at least one staff member per shift trained in advanced paediatric life support. There was still some clarification sought regarding the consultant and middle grade staffing levels and it was agreed to address this again on day 2 site visit.

The co-located Urgent Care model was still being developed and the Panel recommended that the national model that NHS England were developing should be used to develop this further. Similar to the findings from the first Panel review in 2015, public behaviour and choice were discussed at length and there were still some concerns regarding the Urgent Care Centre and the Emergency Department being co-located, with the former accepting children whilst the latter would not, that required careful messaging with the public.

The feedback from the Panel was that it was very apparent that a huge amount of work had been undertaken over the last nine months and that there had been a fundamental shift in culture and engagement. All of the key lines of enquiry that had been identified in advance by the Panel were addressed satisfactorily and the Panel had a clearer picture of the proposed model for ED at the Alexandra Hospital site.

No significant concerns were identified at the end of the first day and the Panel agreed that the site visit would provide the evidence required regarding frontline clinical engagement and support for the model.

Other key lines of enquiry explored during day 1 are as briefly described below and it is accepted that some of these are outside of the ToR for this review but it was agreed with the Programme Board that it was important that these were included in this report to evidence the breadth of evidence and challenge that was covered during this review:

- Management of acute gastrointestinal haemorrhage in medical patients at the Alexandra Hospital site that then required a surgical review
- Intensive Care Unit capacity at the Alexandra Hospital site and how their model of county wide working operated
- The role of the Worcestershire General Practitioners (GPs) in terms of referring the right patient to the correct site e.g. vascular surgical referrals all going to the Worcestershire Royal site
- Current usage of WMAS protocols e.g. all suspected strokes being sent to the Worcestershire Royal site
- Staffing levels and rota patterns in the Emergency Medicine department and the option of rotating staff between sites to maintain levels of experience and developing a county wide service
- Paediatric consultant led assessment model and the anticipated reduction in overnight stays resulting from this being implemented
- Impact of patient choices on surrounding health economies
- Further details requested regarding the capital development build to increase capacity at the Worcestershire Royal site
- Exploration of the fragility of current service provision for surgery and paediatrics to develop a better understanding of why this had happened, what mitigations had taken place and what impacts this would have upon the proposed model for surgery and paediatrics

7 Summary of Day 2

The Panel was again reminded of the scope of the ToR at the start of the day 2 site visit. The Panel reviewed the evidence from day 1 and the following clinical areas identified for the site visit were:

Alexandra Hospital:

- Emergency Medicine Department
- Critical Care
- One panel member requested to see Theatres at AH on the day of the visits
- Acute Medical Consultants

Worcester Royal Hospital:

- Emergency Medicine Department
- Inpatient Paediatrics
- ITU
- Maternity

The key lines of enquiry identified in advance were:

- To explore in detail the proposed model for emergency care provision at the AH site; including the interdependencies and links to primary care, NHS 111, the Urgent Care Centre and the concept of streaming versus triage
- To explore further the Consultant and middle grade capacity at the AH Emergency Medicine department
- To explore further the AH acute medical consultant concerns
- To explore further the current and planned capacity at the WRH site specifically the Emergency Medicine Department
- To understand better the transport issues: rapid transfers between sites and for staff, patients and the public
- To understand better the review of medical and critical care patients at the AH site by the surgical team (surgical team based at the WRH site).

The following does not capture the full breadth of the discussions that were held between the Panel members and the frontline clinical staff due to the nature of the site visit.

The Panel toured the hospitals in a number of groups and the following is a high level summary of their feedback:

- Critical care: the Panel was very impressed with the county wide model of working that the critical care consultants had developed. There was good rotation between sites and in terms of accessing surgical review at the AH critical care unit no problems were identified. The Panel would encourage other specialities to learn from this culture and model of county wide working
- The Panel agreed that there was much greater clarity of vision and support for the proposed model of care at the AH Emergency Medicine Department from both doctors and nursing staff

- The Panel strongly supported an over-16 years old only treatment policy at the AH Emergency Medicine Department; careful messaging, signage and communication with the public would be required to implement this safely
- The planned co-location at the AH of the Urgent Care Centre with the Emergency Medicine Department, with the former treating children and the latter not, would require careful communication with the public to avoid confusion
- The proposed Urgent Care Centre was still in the planning phase - the service specification was being developed and the Panel encouraged the Programme Board to utilise the national models that are being developed by NHS England as a basis for this
- There was support by the Panel for the move toward developing a model that was based upon functionality rather than historical skill mix
- The Panel acknowledged that plans had been developed to mitigate the risks of a 'once in a blue moon' event of a critically ill child being brought into the department by their carers through investing in training of staff in advanced paediatric life support skills with the rotation through the WRH site to maintain clinical practice and skills
- The Panel noted that currently there were only 4 (+1) ED consultants at the AH site; this is not a sustainable level of cover nor is it providing sufficient levels of consultant presence in the department. The Panel strongly recommended the implementation of the Care Quality Commission (CQC) report (2015) to have 10 ED Consultants per site. However, the Panel appreciated the level of dedication and support from the current ED consultants
- Concerns were raised by a minority of clinicians at the WRH site regarding the proposed model for ED and Urgent Care Centre (UCC) at the AH site, specifically regarding patient safety concerns for the treatment of children. This was agreed by the Panel to be explored further on day 3
- Capacity at the WRH Emergency Medicine Department: the Panel accepted that this was the day after a Bank Holiday and that the level of activity may have been above what is normally experienced but concerns remained regarding capacity within the Department and further details regarding capital investment plans and time scales were requested ahead of day 3
- The elective surgery that had moved from the WRH site to the AH site was reported to be working well with fewer operations cancelled due to improved / better bed capacity at the AH

7.1 Summary of Discussions with the Alexandra Hospital acute medical consultants

The Panel met in private with the acute medical consultants from the AH. There was then a joint session between the Panel, acute medical consultants and representatives from the Programme Board and Trust Management. The rationale for this was to determine whether the concerns that the acute medical consultants had would affect the proposed model for the Emergency Medicine Department at the AH site. In summary, the concerns did not specifically relate to this and hence were outside of the ToR for this review. However, due to the interdependencies with the proposed model it was felt important to reflect the discussions within this report.

The following themes were discussed:

- There was strong support to move to a county-wide model of working across the two hospital sites for acute medicine because the current model was not sustainable
- There was a perception of disengagement between the acute medical consultants and the hospital management and a lack of transparent job planning across sites and as a result the AH medical consultants felt that they were not included in recent job adverts, leading to a feeling of isolation.
- Patient safety: views were expressed regarding current patient safety concerns although the consultants could not provide evidence of an increase in reporting of Serious Incidents or increasing Hospital Standardised Mortality Ratio / Summary Hospital-level Mortality Indicator by speciality or location. They reported that they were all working additional hours to mitigate the risks and that this was not sustainable. The issues underlying this were multiple and included:
    - Workforce capacity and an over reliance on locum and agency staff across all grades of staff including medical consultant, middle grade and nursing. The lack of certainty regarding the future model of care across the two sites was compounding this and affecting staff morale
    - There were delays transferring patients from the AH to the WRH site- not due to transport between sites but due to no bed availability at the WRH site leading to delays in patients receiving the specialist care that was required and inequality of access to service provision resulting from this. This was particularly emphasised with regard to patients admitted to AH who were subsequently diagnosed with stroke or required cardiological intervention.
    - New posts being advertised to a WRH base location rather to a county wide model
- Movement of gastroenterology consultants from the AH to the WRH site: concerns were articulated regarding how the remaining AH consultants would be able to access specialist advice and that the service would no longer be compliant with British Liver guidelines.

The representatives from the Trust and the Programme Board responded to these concerns and agreed that further dedicated work was required with this consultant group. There were some immediate actions that could be put in place to mitigate their concerns for example working with the consultants to develop patient safety escalation triggers for Acute Medicine and utilise these in the Quality and Services Sustainability (QSS) group.

8 Summary of Day 3

The Panel submitted key lines of enquiry ahead of day 3 to the Programme Board and as discussed previously in this report not all of the questions were within the remit of the ToR but for completeness they are contained in **Appendix 7**.

The key themes that emerged from the discussion during day 3 relevant to the ToR were as follows:

- There was acknowledgment and consensus from the Panel in terms of the amount of positive progress that has been made since the previous review across all the recommendations but specifically regarding clinical engagement
- There was strong support for the learning from the development of the county wide model of working that had been developed by the anaesthetists to be cascaded across the organisation
- The detail of the model for the UCC compared to the Emergency Medicine Department: (ED) at the AH site. Clarity was sought by the Panel regarding what this would practically mean for patients arriving at the AH site for example: by ambulance, walk in and GP referrals. It was accepted that the service specification was still being developed by the CCGs and that not all of the detail was available at this stage of development because they had been waiting for the national work to be published. The Panel made some observations regarding progress to date including:
    - Support for streaming rather than a triage based model: if the model relied upon a single triage nurse then this may limit capacity and patient flow through the departments
    - There was the need for a careful review of the clinical procedures proposed to be undertaken in the UCC because with only a limited number of staff some of the procedures could be time consuming and more efficiently carried out in the ED setting
    - The staffing levels for consultant level of cover in the ED should match or exceed the planned level of GP level cover in the UCC i.e. 16 hours per day. The rationale underpinning this is that if the ED consultant cover is provided to mitigate against the impacts of a critically ill child attending the AH UCC then comprehensive data presented shows that paediatric admissions do not decrease until ~ 11pm in the evening (based upon the activity figures that the Panel reviewed after submission by the FoAHSW Programme Board).
    - Consideration of the nomenclature for the UCC to manage public expectations of what can be delivered in this setting and again national guidance may help address this.
- Care of children at the AH in the UCC and ED: this was discussed at length both between the Panel members and with the Programme Board, CCGs and representatives from the Trust. The conclusion was reached by the Panel that this was a pragmatic solution that had been developed to address a complicated issue in terms of children being seen at the UCC but not in the ED at the AH site in the future. The Panel reached a majority agreement that children should not be seen in an ED where there were not any future planned inpatient paediatric facilities, as per the plans for the AH site. The Panel was

only aware of one other ED in the country where this was not the case-all other EDs that accepted children had inpatient paediatric beds. Careful management of public expectations would be required to ensure that children were taken to the right location for the level of care that they required. West Midlands Ambulance Service shared the learning from the protocols that had been developed in other parts of the West Midlands (WM) and this provided reassurance to the Panel that children would be taken to the correct location in a timely manner: including the ability for Paramedics to administer antibiotics in cases of suspected meningococcal meningitis so that delays were not introduced travelling further distances to WRH for children from the Redditch locality. Similarly, for minor ailments where carers had called for an ambulance inappropriately these could be taken to the UCC at the AH site rather than potentially travel further distances to WRH. Careful consideration will need to be taken in identifying which type of cases should go directly to WRH (e.g. deformed fracture or neurovascular complications) and which will go to AH. Impending UCC national guidance may help with this. The Panel felt strongly though that the ED at the AH should continue to make plans to ensure that critically ill children can be treated there although this would not be advertised to the public. This was based upon the clinical experience of the adult only EDs in other parts of the country where occasionally they would have to resuscitate a critically ill child. This could be achieved through: ensuring adequate numbers of staff are trained in advanced paediatric life support but also development of a county wide model of working where middle grade and consultant staff rotate through the WRH or other Providers of paediatric care e.g. Birmingham Children's Hospital to maintain their skills and experience. This was important because it was noted that having undertaken an advanced paediatric life support qualification did not then give an individual the experience and on-going maintenance of skills to lead the full range of care required for treating critically ill children. In addition, it was suggested that the out of hours rota could be developed based around a specific base location to meet the requirement of a 20 min response time to the ED department by the consultant workforce i.e. not all ED consultants would be expected to provide out of hours cover to both sites.

- Consultant staffing levels of the ED departments at both the WRH and AH were discussed: the Panel strongly supports the implementation of the CQC Quality Report (2015) to have 10 ED Consultants on each site to provide and deliver a safe and clinically sustainable model of care
- Impacts of the change in model at the AH on West Midlands Ambulance Service: as noted in the previous Panel report from June 2015 there would be the requirement for additional ambulances to be provided due to increased journey times and transfers between the WRH and AH sites. The Panel accepted that commissioners had been involved with developing this requirement further and agreed that the impacts of this were still relevant. The modelling shows that at least one additional ambulance is required. This ambulance must be in place before any additional transfers due to the reconfiguration commencing or the proposed changes may fail. This could be a rate limiting step.
- Capital build plans at the WRH site: the Panel had concerns regarding the current bed capacity at the WRH site following the site visit on day 2 and the modelling data submitted for review. The Panel felt that the planned reduction

in demand modelling was optimistic. However, details for future capital build plans at the WRH site were discussed and this provided assurances to the Panel regarding where additional bed capacity could be located in the future on this site including additional parking spaces and the park and ride schemes for staff during day light hours. The Panel felt that timely approval and finances would be instrumental in taking this forward.

- Transport for public and staff: it was accepted that further work had been undertaken since the first review and that important lessons had been learnt following the relocation of maternity services from the AH to WRH site i.e. the shuttle bus that was provided was not used and the Trust had not received a single complaint related to transport. The Healthwatch Worcestershire representative provided assurances that work regarding transport was on going with the Local Authority and with approximately 80 different community groups to try to mitigate the transport challenges of this rural locality.

9 Recommendations, Conclusions and Advice

9.1 Recommendations

Recommendation from June 2015 first Panel review	Summary of recommendation from second Panel review May 2016
The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	The Panel concluded this recommendation has been addressed. The evidence presented included the current activity modelling, development of a consultant-led paediatric assessment unit at the WRH site to improve triage, assessment and observation and to reduce length of stay with increasing the provision of care in the community
The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety	The Panel concluded that this recommendation has been met. The Panel now approves the model of emergency care for the AH site based upon the evidence presented including greater clarity of vision regarding the practicalities of the model, the proposed staffing levels and skill mix and frontline clinical support for the model. The Panel made recommendations regarding future Consultant workforce levels and the need for clarity regarding the difference between the Emergency Medicine Department and the co-located Urgent Care Centre specifically with respect to paediatrics
The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	The Panel concluded that this recommendation has been addressed and was appropriate for this stage of development of the model. Even so, the Panel continued to have concerns regarding public behaviour that it believed would need to be addressed during the wider consultation and public engagement phases of development.

The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.	The Panel conclude that this recommendation has been addressed. Outside of the ToR relating to the model of Emergency Medicine provision at the AH, the Panel heard evidence from the acute medical consultants at the AH and recommends that further engagement work is done with this group to address their patient safety concerns.

In addition the Panel developed the following recommendation:

- The concerns raised by the acute medical consultants at the Alexandra Hospital site cannot be ignored because of the interdependencies with the Emergency Medicine Department. The perception of current patient safety concerns specifically need further exploration with the identification of patient safety triggers for Acute Medicine through the QSS Group and the movement towards county wide working is encouraged by the Panel.

9.2 Conclusions

The Panel acknowledged that a significant amount of progress has been made since the first review held in June 2015; specifically notable was the clinical engagement but also the openness to the constructive challenge provided by this Panel. Carefully managing public expectations and communications regarding the proposal of developing a 16 years + Emergency Medicine Department and a co-located Urgent Care Centre at the AH site would be vital to the success of the model. The Panel has made some recommendations regarding minimising the risk associated with a critically ill child presenting at the AH site that it would strongly encourage consideration prior to implementation, specifically the consultant staffing levels and the development of a county wide model of working to maintain experience and skills.

9.3 Advice

The following advice has been developed by the Panel following the conclusion of the review:

- It was noted that the majority of the Executive Team at this Provider are on an interim basis. The Panel strongly feels that substantive appointments need to be made to continue with the good momentum that has been made over the last nine months and the palpable change in culture and attitude to staff engagement
- The lessons learnt from the anaesthetic department in terms of developing their county wide model of working are identified and shared wider across the Trust as an example of good practice
- The staffing levels for the ED consultants needs to be at a minimum level of 20 across (10 on each site) the 2 hospital sites to provide a safe and sustainable level of cover as per the CQC Quality Report (2015) advice
- It was suggested that the normal working day for the Emergency Medicine consultants is based upon a county wide rotational basis to retain skills in terms of care of paediatrics at the WRH site. This could be separate from the out of hours provision with the identification of a main site reflecting that not all consultants will live within a response time of 20 minutes

- Middle grade and ED consultants at AH need to rotate to maintain paediatric experience-this could be through experience at WRH as above or at alternative Providers e.g. Birmingham Children's Hospital
- The FoAHSW Programme Board is encouraged to utilise the national model for Urgent Care service specification that is being developed by NHS England
- Support for streaming rather than a triage based model: if the model relied upon a single triage nurse then this may limit capacity and patient flow through the departments
- There was the need for a careful review of the clinical procedures proposed to be undertaken in the UCC because, with only a limited number of staff, some of the procedures could be time consuming and more efficiently carried out in the ED setting
- The staffing levels for consultant level of cover in the ED should match or exceed the planned level of GP level cover in the UCC i.e. 16 hours per day. The rationale underpinning this is that if the ED consultant cover is provided to mitigate against the impacts of a critically ill child attending the AH UCC then comprehensive data presented shows that paediatric admissions do not decrease until ~ 11pm in the evening (based upon the activity figures that the Panel reviewed after submission by the FoAHSW Programme Board).
- Consideration of the nomenclature for the UCC to manage public expectations of what can be delivered in this setting and again national guidance may help address this
- The Panel strongly supports additional further work being undertaken between the Programme Board, Trust Management and acute medical consultants across both sites to develop the vision and implementation for sustainable county wide working

10 References and Glossary of Terms

http://www.bsg.org.uk/clinical-guidelines/liver/index.html (accessed 18.5.16)

Care Quality Commission (02/12/2015) Quality Report, Worcestershire Acute Hospitals NHS Trust, http://www.cqc.org.uk/provider/RWP (accessed 18.5.16)

Future of Acute Hospital Services in Worcestershire Case for Change (2012)

Future of Acute Hospital Services in Worcestershire Case for Change (2014)

Future of Acute Hospital Services in Worcestershire Joint Service Review (2012)

NHS England, (undated), Urgent and Emergency Care Route Map http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx (accessed 18.5.16)

NHS England, (2015), West Midlands Clinical Senate – The Future of Acute Hospital Services in Worcestershire Stage II Clinical Assurance Review Panel Final Report http://www.wmscnsenate.nhs.uk/clinical-senate/publications/west-midlands/current/stage-ii-assurance/ (accessed 18.5.16)

Worcestershire Acute Hospitals NHS Trust, 2013/2014 Annual Plan http://www.worcsacute.nhs.uk/ (accessed 18.5.16)

Worcestershire Acute Hospitals NHS Trust, Integrated Business Plan (2014/15-2018/19

The following list is a glossary of terms used throughout the ICRP report:

A&E – Accident and Emergency
AH – Alexandra Hospital
CCG – Clinical Commissioning Group
CEM – College of Emergency Medicine
CQC – Care Quality Commission
ED – Emergency Medicine Department
FoAHSW – Future of Acute Hospital Services in Worcestershire
GPs – General Practitioners
HEWM – Health Education West Midlands
HSMR – Hospital Standardised Mortality Ratios
ICRP – Independent Clinical Review Panel
ICRT – Independent Clinical Review Team
JSR – Joint Services Review
KHTC – Kidderminster Hospital and Treatment Centre
MIU – Minor Injuries Unit
QSS – Quality and Service Sustainability Sub-Committee
RCPCH – Royal College of Paediatrics and Child Health
ToR – Terms of Reference
UCC – Urgent Care Centre
WAHT – Worcestershire Acute Hospitals NHS Trust

WM – West Midlands
WMAS – West Midlands Ambulance Service
WMCS - West Midlands Clinical Senate
WRH – Worcestershire Royal Hospital

11 Appendices

12 Appendix 1 Terms of Reference

NHS England

West Midlands Clinical Senate

Future of Acute Hospital Services in Worcestershire (FoAHSW) Stage 2 (b) Review

Terms of Reference

THE NHS CONSTITUTION
the NHS belongs to us all

West Midlands Clinical Senate

Future of Acute Hospital Services in Worcestershire (FoAHSW) Review

Terms of Reference

First published: March 2016

Prepared by: West Midlands Clinical Senate

TERMS OF REFERENCE

Independent Clinical Review of The Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme

Sponsoring Organisation: FoAHSW Programme Board
Clinical Senate: West Midlands

NHS England (regional or area team): NHS England, West Midlands

Terms of reference agreed by:

Name: Dr David Hegarty on behalf Clinical Senate

Date: 23.03.16

Name: Joanna Newton on behalf of sponsoring organisation

Date: 01.04.16

1. Clinical Review Team Members

Chair and Vice Chair:

Name	Position	Organisation
Dr Helen Carter	Deputy Director of Healthcare, Public Health and Workforce	Public Health England West Midlands
Prof Guy Daly	Executive Dean of Faculty of Health and Life Sciences	Coventry University

Members:

Name	Position	Organisation
Dr Rashid Sohail	Deputy Medical Director	East Midlands Ambulance Service
Mr Keith Spurr	Patient and Public Representative	East Midlands Strategic Clinical Network and Senate
Dr Peter Marc-Fortune	Consultant Paediatric Intensivist	Central Manchester University Hospital
Prof Ian Greaves	Professor in Emergency Medicine	South Tees Hospitals NHS Foundation Trust
Mr Athur Harikrishnan	General and Colorectal Surgeon	Sheffield Teaching Hospital NHS Foundation Trust
Prof Edward Davis	Orthopaedic Surgeon	The Royal Orthopaedic Hospital, Birmingham

Dr Helen Hurst	Advanced Nurse Practitioner	Manchester Royal Infirmary
Ms Andrea Pope Smith	Retired Director of Social Care	n/a
Dr Andrew Phillips	General Practitioner	NHS Vale of York CCG
Mr Peter Sedman	*General Surgeon*	Hull Royal infirmary
Mr Duncan Learmonth	Orthopaedic Surgeon	The Priory Birmingham
Ms Penny Snowden	Deputy Chief Nurse	United Lincolnshire Hospitals
Dr Jackie McLennan	Senior Emergency Medicine Consultant	Manchester
Dr Richard Elliott	Consultant Anaesthetist	Royal Derby Hospital
Mr Murray Spittal	Consultant Anaesthetist	United Lincolnshire Hospitals
In attendance		
Rob Wilson	Interim Associate Director	West Midlands SCN and Clinical Senate
Angela Knight Jackson	Clinical Senate Manager	West Midlands SCN and Clinical Senate
Karen Edwards	Clinical Senate PA	West Midlands SCN and Clinical Senate
Rachel Knowles	Clinical Senate Admin Support	West Midlands SCN and Clinical Senate

N.B; All clinical review team members will sign a declaration of conflict of interest and confidentiality agreement (see appendix 1 and 2), and their names and affiliations will be published in the Clinical Senate review report.

2. Aims and Objectives of the Clinical Review

2.1 Aim

To re-assess the clinical quality, safety and sustainability of the redeveloped Summary Model for Emergency Care, against the recommendations made in the final report of the West Midlands Clinical Senate review, published on 11th June 2015, and to ensure suggested changes will not compromise interdependencies with other parts of the model which have already been successfully reviewed. Any changes already instigated since the Senate review, published on 11th June 2015, should be made known and available to the West Midlands Clinical Senate Review Panel to ensure they are consistent with the clinical quality, safety and sustainability of the overall model.

2.2 Objectives

The Independent Clinical Review Panel will:

a) Review and re-assess the redeveloped clinical model for Emergency Care against the recommended criteria set out in the FINAL report of the West Midlands Clinical Senate review, June 2015 (full recommendations are available in appendix 3):

Recommendation number	**Recommendations from FINAL report of WMCS (June 2015)**	
1: Obstetrics and Gynaecology and Emergency Surgery	The Panel supports the proposals set out within the Summary Model of Care to reconfigure the Obstetrics and Gynaecology and Emergency Surgery services through transferring these from Alexandra Hospital and consolidating them onto the Worcestershire Royal Hospital site.	Recommendation previously supported by the West Midlands Clinical Senate (WMCS) and therefore this element of the model is out with the scope of this WMCS review.
2: Inpatient Paediatrics	The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	This would need to include: 1. A clear plan and risk assessment of the likely shortfall of paediatric nursing recruitment at the WRH site 2. The expansion of car parking/park and ride provision at WRH to cope with the increased demands of those travelling by car from Redditch and Bromsgrove.
3: Urgent Medical Care	The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety.	These concerns relate to issues of: 1. Sustainable staffing, with a national shortage of ED Consultants, middle grades and

		the potential for trainees to be removed from the AH site 2. Public and staff misunderstanding of the model of Emergency Medical Care at AH (see also Recommendation 4, below) 3. Increased clinical risk arising from the removal of key services from AH aligned to the management of emergency care, including Inpatient Paediatrics and Emergency Surgery - and their further critical interdependencies with other clinical specialties, including Anaesthetics and Critical Care.
4: Urgent Medical Care for Children at AH	The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	This should include: 1. Making absolutely explicit the extent and remit of urgent/emergency paediatric cover 2. Having a clear plan for dealing with paediatric emergency presentations at AH out of hours 3. Undertaking a full risk assessment in respect of any proposals for paediatric emergency provision that are less than 24/7 4. A detailed consideration of how seriously unwell children presenting at the AH site, who do not meet critical care transport team criteria, will be safely transferred to the WRH site. This should encompass personnel, equipment and transport logistics.
5: Engagement and Co-ownership from Frontline Clinical Workforce	The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability	

b) Consider the final clinical model for Emergency Care prior to public consultation against the above criteria and make recommendations on whether to support the model to the West Midlands Clinical Senate Council and thereafter to FoAHSW Programme Board and sponsoring organisations.

3. Timeline

Work is taking place with NHS England to ensure the FoAHSW programme progresses in a timely manner. NHS England has stated that their assurance process should ideally be completed by June 2016. Given these timescales, and that this is a review revision rather than a complete review, the timeline will proportionately reflect this. Taking these factors into consideration a suggested timeline is indicated below:

Week Beginning	Action	Organisation
22/02/2016	Teleconference re arrangements for the Panel assessment, site visits and reporting	CS, CCG's, FoAHSW Programme Board
23/03/2016	Agree terms of reference	CS, CCG's, FoAHSW Programme Board
28/03/2016	CS request for documentation from the sponsoring organisation	CS
04/04/2016	CS receives documentation from the sponsoring organization	CCG's, FoAHSW Programme Board
11/04/2016	Documentation sent to ICRT	CS
21/04/2016	First Panel assurance	CS
03/05/2016	Second Panel assurance and site visit	CS
16/05/2016	Third Panel assurance and conclude review	CS
23/05/2016	Report draft to CCGs	CS, CCG's, FoAHSW Programme Board
30/05/2016	Finalise report	CS
w/e 13/06/16	Virtual WMCS Board for sign off	CS

4. Methodology

The role of the review team will be to examine documentary evidence, and decide recommendations. The West Midlands Clinical Senate acknowledges that the sponsoring organisations (NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG), have undergone a first, and second stage assurance review as a component of the NHS England assurance process and is now ready to undertake a 2(b) stage assurance external expert review as part of the FoAHSW review programme (see Appendix 4 NHS England Assurance process) .

The 2(b) assurance review will be carried out in line with the key tests, and an appropriate selection of best practice checks as a component of the NHS England final assurance process. The Clinical Senate (through its Council) will be responsible for the review being carried out.

A formal report containing clinical senate advice will be returned to the CCG's via the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme Board who will share it with NHS England as part of their assurance evidence.

The West Midlands Clinical Senate acknowledges that the sponsoring organisation has undertaken an external expert review as part of the FoAHSW Reconfiguration programme and the report will be made available to the Panel.

It is anticipated that the review will take place during April and May 2016.

The clinical review team will need to consider the following;

- Has the review revision satisfactorily met all the recommendations detailed in the WMCS report, published June 2015?
- Has relevant available evidence been effectively marshalled and applied to the specifics of the proposed scheme?
- Is there alignment with other national, regional and local intentions?
- Is there evidence of clinical overstatement or optimism bias in the proposals?

5. Reporting

A draft report from the Clinical Review Team will be made available to the sponsoring organisation for fact checking prior to publication. Any comments / correction must be received within 5 working days.

The Clinical Review Team will submit a draft report (see Independent Clinical Review Team Report Template appendix 5) to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report. The council may wish to take a view or offer advice on any issues highlighted that should be taken into consideration in implementing change.

The Council will be asked to comment specifically on the:

- Comprehensiveness and applicability of the review
- Content and clarity of the review and its suitability to the population in question
- Interpretation of the evidence available to support its recommendations
- Likely impact on patient groups affected by the reconfiguration
- Likely impact / ability of the health service to implement the recommendations

The final report will be submitted to the FoAHSW Programme Board by June 2016 and the clinical advice will be considered as part of the NHS England's West Midlands assurance process for service change proposals. The report is not expected to comment upon issues of the NHS England assurance process that will be reviewed elsewhere (e.g. patient engagement, GP support or the approach to consultation).

The review report will remain confidential until placed in the public domain at the conclusion of the review process and /or with agreement with the sponsoring organisation(s).

6. Communication and Media Handling

The Clinical Senate review will be published on the website of the Clinical Senate and council and assembly members will provide support to disseminate the review at local level. The sponsoring organisation(s) will handle all media inquiries in the first instance. The Clinical Senate may engage in various activities with the sponsoring organization(s) to increase public, patient and staff awareness of the review.

7. Resources

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

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation(s).

8. Accountability and Governance

The clinical review team is part of the West Midlands Clinical Senate accountability and governance structure.

The West Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation(s).

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

9. Functions, Responsibilities and Roles

9.1. The sponsoring organisation(s) will:

- Provide for the clinical review Panel all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, 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).
- Respond within the agreed timescale to the draft report on matter of factual inaccuracy. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
- Submit the final report to NHS England for inclusion in its formal service change assurance process.

9.2 Clinical Senate Council and the sponsoring organisation(s) will:

- Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.
- Clinical Senate council will:
    - Appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member.
    - endorse the terms of reference, timetable and methodology for the review
    - endorse the review recommendations and report
    - provide suitable support to the team.
    - Submit the final report to the sponsoring organisation(s)

9.3 Clinical review team will:

- Undertake its review in line with the methodology agreed in the terms of reference
- Follow the report template and provide the sponsoring organisation(s) with a draft report to check for factual inaccuracies.
- 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.
- Keep accurate notes of meetings.

9.4 Clinical review team members will undertake to:

- Commit fully to the review and attend all briefings, meetings, interviews, Panels etc that are part of the review (as defined in methodology).
- Contribute fully to the process and review report
- Ensure that the report accurately represents the consensus of opinion of the clinical review team.
- 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 clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

Appendix 1 (of ToR)

Declaration of Conflict of Interest

West Midlands Clinical Senate Independent Clinical Review Team
Future of Acute Hospital Services in Worcestershire (FoAHSW)
Stage II Part B

To be completed by all members of the clinical review team. Clinical Senate Council members should also consider if they have any conflicts in considering the review team's report.

For advice on what items should and should not be declared on this form refer to the Conflicts of Interest Policy issued by the West Midlands Clinical Senate. Further advice can also be obtained from the Clinical Senate Manager.

Name:

Position:

Please describe below any relationships, transactions, positions you hold or circumstances that you believe could contribute to a conflict of interest:

For completion

Type of Interest – Please supply details of where there is conflict in accordance with the following list:

A direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

An indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

A direct non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

An indirect non-pecuniary interest: where an individual is closely related to, or in a relationship, including friendship, with an individual in categories a-f.

A direct non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

An indirect non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value but is a benefit to peers or colleagues (for example, a recommendation which results in an increase in revenue or status to their employing organisation or results in their organisation becoming the preferred provider).

An indirect non-pecuniary conflict: where the evidence of the senate may bring a member into direct or indirect conflict with their contracting or employing organisation, to the extent that it may impair the member's ability to contribute in a free, fair and impartial manner to the deliberations of the senate council, in accordance with the needs of patients and populations.

Other – please specify

Name	
Type of Interest	
Details	
Action Taken	
Action Taken By	
Date of Declaration	

I hereby certify that the information set forth above is true and complete to the best of my knowledge.

Signature:

Name:

Date:

Appendix 2 (of ToR)

Confidentiality Agreement

West Midlands Clinical Senate Independent Clinical Review Team
Future of Acute Hospital Services in Worcestershire (FoAHSW)
Stage II Part B

I (name) …….
hereby agree that during the course of my work (as detailed below) with the West Midlands clinical senate I am likely to obtain knowledge of confidential information with regard to the business and financial affairs of an NHS body, or other provider, its staff, clients, customers and suppliers, details of which are not in the public domain ('confidential information') and accordingly I hereby undertake to and covenant that:

I shall not use the confidential information other than in connection with my work; and

I shall not at any time (save as required by law) disclose or divulge to any person other than to officers or employees of West Midlands clinical senate, other NHS organisations, staff, clients, customers and suppliers whose province it is to know the same any confidential information and I shall use my best endeavours to prevent the publication or disclosure of any confidential information by any other person.

The restrictions set out above shall cease to apply to information or knowledge that comes into the public domain otherwise than by reason of my default of this Agreement.

The 'Work' (clinical review) is:
Future of Acute Hospital Services in Worcestershire (FoAHSW)
Signed _____ Date: _____

Name (caps) _____

Appendix 3 (of ToR)

Recommendations from the final report of the West Midlands Clinical Senate published on 15th June 2015. A copy of the full report can be accessed from the West Midland Clinical Senate website here.

13.1 Recommendations

Recommendation 1: Obstetrics and Gynaecology and Emergency Surgery

The Panel **supports** the proposals set out within the Summary Model of Care to reconfigure the Obstetrics and Gynaecology and Emergency Surgery services through transferring these from AH and consolidating them onto the WRH site.

Recommendation 2: Inpatient Paediatrics

While the Panel **supports in principle** the proposal set out within the Summary Model of Care to transfer Inpatient Paediatrics from AH to the WRH site, it remains concerned, however, regarding the capacity to accommodate additional paediatric inpatients from Redditch and Bromsgrove at WRH. The proposed model of care relies on ambitious plans to reduce the average length of hospital stays through prompt discharge of children into the community for on-going care. The ability to achieve this objective is a risk, the extent of which needs to be clearly understood and managed.

The Panel, therefore, **recommends** that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at WRH in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.

This would need to include:

- A clear plan and risk assessment of the likely shortfall of paediatric nursing recruitment at the WRH site
- The expansion of car parking/park and ride provision at WRH to cope with the increased demands of those travelling by car from Redditch and Bromsgrove.

Recommendation 3: Urgent Medical Care

While the Panel endorses the previous Independent Clinical Review Panel's findings that some form of ED provision is required at the AH site, the Panel **does not support** the detail of the proposed model of Emergency Medicine at AH as set out within the Summary Model of Care.

The Panel has a number of concerns with the detail of the model of Emergency Medicine at AH with respect to patient safety. These concerns relate to issues of:

- Sustainable staffing, with a national shortage of ED Consultants, middle grades and the potential for trainees to be removed from the AH site
- Public and staff misunderstanding of the model of Emergency Medical Care at AH (see also Recommendation 4, below)
- Increased clinical risk arising from the removal of key services from AH aligned to the management of emergency care, including Inpatient Paediatrics and

Emergency Surgery - and their further critical interdependencies with other clinical specialties, including Anaesthetics and Critical Care.

Recommendation 4: Urgent Medical Care for Children at AH 2
The Panel was particularly concerned about the practicalities and clinical risks associated with the delivery of the proposed model of urgent medical care for children presenting at the AH site, as well as by the varying interpretations of the proposed paediatric service model at AH that it had received from frontline staff.

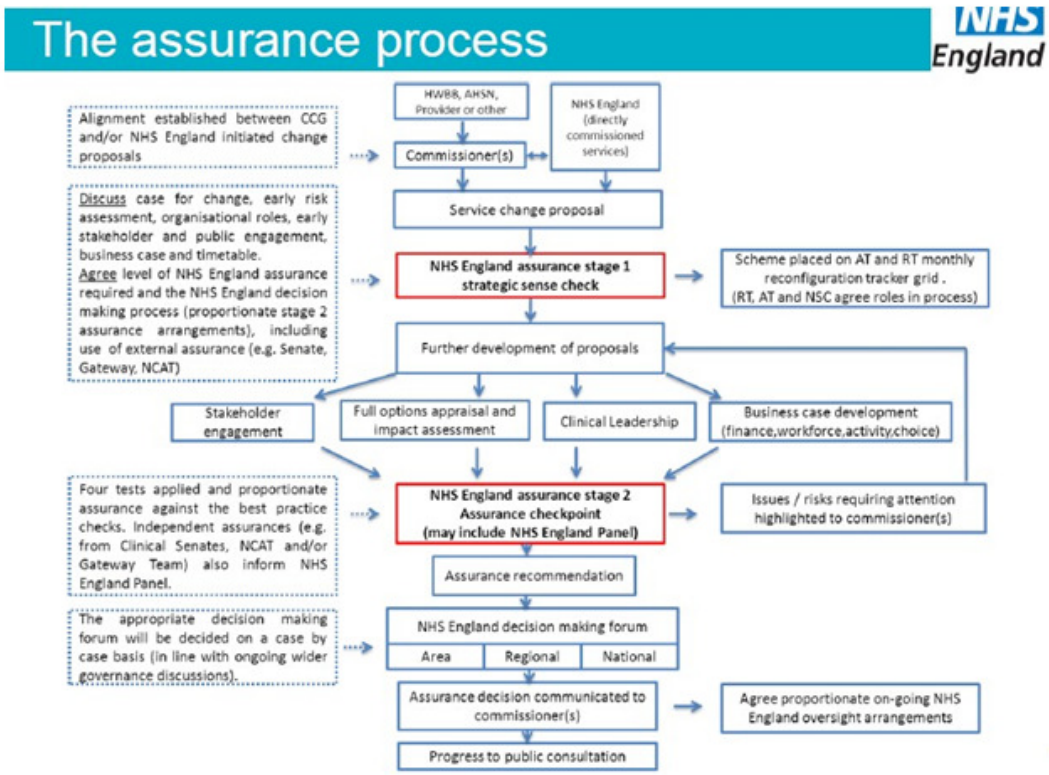
The Panel, therefore, strongly **recommends** that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when. This should include:

- Making absolutely explicit the extent and remit of urgent/emergency paediatric cover
- Having a clear plan for dealing with paediatric emergency presentations at AH out of hours
- Undertaking a full risk assessment in respect of any proposals for paediatric emergency provision that are less than 24/7
- A detailed consideration of how seriously unwell children presenting at the AH site, who do not meet critical care transport team criteria, will be safely transferred to the WRH site. This should encompass personnel, equipment and transport logistics.

Recommendation 5: Engagement and Co-ownership from Frontline Clinical Workforce
The Panel accepted that a certain amount of clinical engagement had taken place within WAHT to develop the proposed model of care for the 'Emergency Centre' at the AH site. During Day 4, however, it became apparent that there was not strong clinical support for this model, due to concerns about patient safety and service sustainability.

The Panel, therefore, **recommends** that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.

Appendix 4


The assurance process
NHS England
HWBB, AHSN, Provider or other
NHS England (directly commissioned services)
Alignment established between CCG and/or NHS England initiated change proposals
Commissioner(s)
Service change proposal
Discuss case for change, early risk assessment, organisational roles, early stakeholder and public engagement, business case and timetable.
Agree level of NHS England assurance required and the NHS England decision making process (proportionate stage 2 assurance arrangements), including use of external assurance (e.g. Senate, Gateway, NCAT)
NHS England assurance stage 1 strategic sense check
Scheme placed on AT and RT monthly reconfiguration tracker grid . (RT, AT and NSC agree roles in process)
Further development of proposals
Stakeholder engagement
Full options appraisal and impact assessment
Clinical Leadership
Business case development (finance,workforce,activity,choice)
Four tests applied and proportionate assurance against the best practice checks. Independent assurances (e.g. from Clinical Senates, NCAT and/or Gateway Team) also inform NHS England Panel.
NHS England assurance stage 2 Assurance checkpoint (may include NHS England Panel)
Issues / risks requiring attention highlighted to commissioner(s)
Assurance recommendation
The appropriate decision making forum will be decided on a case by case basis (in line with ongoing wider governance discussions).
NHS England decision making forum
Area
Regional
National
Assurance decision communicated to commissioner(s)
Agree proportionate on-going NHS England oversight arrangements
Progress to public consultation

Appendix 5 (of ToR)

West Midlands Clinical Senate Independent Clinical Review Team Report Template

Future of Acute Hospital Services in Worcestershire (FoAHSW)

[senate email]@nhs.net

Date of publication to sponsoring organisation:

CHAIR'S FOREWORD (Clinical Review Team)

Statement from Clinical Senate Chair

SUMMARY & KEY

RECOMMENDATIONS

BACKGROUND

- [CLINICAL AREA]
- [Description of current service model]
- [Case for change]
- [Review methodology]
- Details of approach taken, review team members, documents used, sites visited, interviewees]
- [Scope and limitations of review]
- [Recommendations]

CONCLUSIONS AND ADVICE

[References]
This should include advice against the test of 'a clear clinical evidence base' for the proposals
and the other checks defined in the terms of reference agreed at the outset of the review.
Has the proposal been founded on robust clinical evidence? What evidence has been used and how has it been applied to local circumstances?
Has the available evidence been marshalled effectively and applied to the specifics of the proposed scheme?

GLOSSARY OF TERMS

APPENDICES:

Terms of reference
Clinical review team members and any declarations of interest
Background information

13 Appendix 2 ICRT Panel Members' Biographies

MEMBER BIOGRAPHY/PROFILE

Name	Dr Helen Carter
Dr Helen Carter is the Vice Chair of the West Midlands Clinical Senate. She is a medical doctor by background who moved into Public Health Medicine in 2001. She has worked in a variety of organisations including: health authorities, Primary Care Groups and Trusts, Strategic Health Authority and joined Public Health England in 2013. Her current portfolio includes generic healthcare public health, screening and immunisations, specialised commissioning, dental public health and public health workforce development.	

Name	Prof Guy Daly
Professor Guy Daly is Executive Dean of the Faculty of Health and Life Sciences at Coventry University. The Faculty educates and trains some ten or more health and social care professionals. In addition, Professor Daly is a; Non-Executive Director of Coventry and Warwickshire Partnership NHS Trust (and Chair of its Safety and Quality Committee) Member of Health Education England - West Midlands Local Education and Training Board Member of Coventry Health and Wellbeing Board. He is a social policy academic and researches in the areas of social care, local policy, housing and health.	

Name	Dr Rashid Sohail
Dr Rashid joined East Midlands Ambulance Service in 2013 as Deputy Medical Director and has been a consultant in emergency medicine since 2000. He continues to practice clinically on a part-time basis. He has previous experience as a Clinical Director of Emergency Medicine and Chair of Medicine with North West Deanery Health Education. As well as his clinical knowledge Rashid is an Assistant Coroner in Manchester City Jurisdiction and a Member of Coroners Society of England & Wales.	

Name	Mr Keith Spurr

Professionally; A retired HR Professional and an accredited Trade Union Representative. Represented both Organisations and Individuals at Employment Tribunals.

Patient Representative Role; Diabetic Type 1. Since retirement, recognised as the Diabetes UK Champion for the South Lincolnshire Area and a diabetic "voice". Endeavouring to improve the facilities of Diabetic support especially education. Organised a Diabetes Education Event in Stamford and established a self-help group for people with diabetes.

Member of the East Midlands Clinical Senate and a National PPV for NHS England.

A member of Lincolnshire Healthwatch. Secretary to St Mary's Medical Centre PPG

Name	Dr Peter-Marc Fortune

Peter-Marc Fortune is a Consultant Paediatric Intensivist based at Royal Manchester Children's Hospital since 2002. He was Clinical Director of Critical Care from 2005-2012 and has been Associate Clinical Head of the Hospital since then.

He has interests in patient safety, resuscitation, ethics and medical education. He is currently President-Elect of the Paediatric Intensive Care Society, Chair of the Making it Safer Together (MiST) children's patient safety collaborative, a member of The NHS England Children's Patient Safety Expert Group, a member of the Resuscitation Council (UK) Executive Committee, and chair of the NAPSTaR and Human Factors working groups of the Advanced Life Support Group.

Name	Prof Ian Greaves

Colonel Ian Greaves qualified in medicine at Birmingham in 1986 and trained in emergency medicine in Yorkshire before joining the Armed Forces on appointment as a consultant in Peterborough in 1997. Since 2002, Colonel Greaves has been consultant in emergency medicine at James Cook University Hospital in Middlesbrough which is now a regional major trauma centre. He was appointed to a visiting professorship in emergency medicine at the University of Teesside in 2003.

In civilian life, Professor Greaves leads the Academic Department of Emergency Medicine at the University of Teesside and James Cook Hospital which has received a number of major grants and established a particular reputation in the field of mild traumatic brain injury (mTBI) research. The department is strongly committed to multi-professional research and currently has nursing PhD and paramedic MSc fellows.

Professor Greaves has published widely in the fields of trauma, pre-hospital care and

military medicine. Formerly the editor of the Journal of the Royal Army Medical Corps, he now edits the quarterly journal Trauma. Professor Greaves has written or edited ten textbooks including key texts in the field of Immediate Care and paramedic practice and contributed to a wide range of other books. He lectures widely on all aspects of pre-hospital care and trauma management. He was formerly a member of the Executive and Faculty Board of the Faculty of Pre-hospital Care and is the secretary of the charity Trauma Care. He recently served on the Department of Health Clinical Advisory Group on Pre-hospital and Transfer Medicine.

Still a serving officer, Colonel Greaves was tri-service lead for emergency medicine and pre-hospital care from 2008 – 2014, responsible for co-ordinating the delivery of an emergency medicine capability in the UK and on operations in Afghanistan. He has deployed to both Iraq and Afghanistan. From 2010–2014. Colonel Greaves was Honorary Surgeon to HM Queen Elizabeth II. He lives in a small Yorkshire Dales village with his wife, two sons and a menagerie of assorted animals his children promised to clean up after. One day, he will finish his masterpiece on the historical architecture of north Yorkshire and complete his model railway.

Name	Dr Helen Hurst

Helen Hurst has worked in renal medicine for over 25 years, working in all areas of renal medicine and community. Since 2000 she has worked as an advanced nurse practitioner in the renal drop-in service at Manchester Royal Infirmary; developing and growing the service to enhance ambulatory care. She has been involved in research and completed a PhD in 2011 in patient experience and has collaborated on many research projects; including publications, and is a regular reviewer for specialist and nursing journals.

She is an active member of the British Renal Society, co-chair of the upcoming conference and a member the International Society of Peritoneal Dialysis Education Committee. She is also a member of the Clinical Senate for the region. She is an associate member of the Research and Development North West team. She has formulated a renal patient research group and is interested in patient involvement and collaboration in research. She has presented nationally and internationally and has recently collaborated with Manchester University to set up the renal course for nurses and is the clinical lead. Helen has also been involved in the Well North Project, a strategic collaborative programme funded by Public Health England which seeks to tackle the wider social determinants underlying substantive health inequalities. More recently Helen has been asked to lead a project within the Trust on ‘open visiting’ and has been awarded a CLAHRC fellowship.

Name	Mr Peter Sedman
Peter Sedman is a Consultant Upper Gastrointestinal Surgeon in Hull, where he was appointed in 1995. He leads the Upper GI Unit there and Chairs the Medical Advisory Committee of the local private hospital. Peter Sedman is currently the President of the Association of Laparoscopic Surgeons of Great Britain and Ireland (ALSGBI) and sits on the Yorkshire and the Humber Clinical Senate of the NHS.	

Name	Dr Jackie McLennan
Lt Col Jackie Mclennan trained at Leicester University and qualified as a doctor in 1998 while being sponsored by the Royal Army Medical Corps. She undertook house officer jobs at The Glenfield, Leicester Royal infirmary and Leicester General Hospital. SHO jobs were at Peterborough Hospital, Frimley Park Hospital in Camberley, Surrey and underwent officer training at the Royal Military Academy Sandhurst. This training was interspersed with deployments to Northern Ireland, Kosovo and Iraq. Training as a Registrar was based initially at the James Cook University Hospital, Middlesbrough, before moving to the North Western Deanery where she rotated though Manchester Royal Infirmary, Stepping Hill Hospital and Wythenshawe Hospital. She started Work as a consultant in Emergency Medicine in June 2010 at Manchester Royal Infirmary where she was part of the team that worked on the massive transfusion protocols across the region and completed a doctorate on production of a clinical decision rule to help guide people on the need for massive transfusion in major trauma. She has recently started work as a consultant in Emergency Medicine at the Royal Stoke University Hospital and continues to be a Consultant in the Defence Medical Services.	

Name	Dr Richard Elliott
Qualified in 1980 MB BCh (Wales). FRCA 1987 Lecturer in University of Calgary, Canada 1989. Consultant Anaesthetist in Derby appointed in 1992. Service Director and Lead Clinician in Anaesthesia/Critical Care for 6 years. Member of Reshaping Health Services in Derby, leading to new hospital design/build. Chair Mortality review group for 12 yr. Member of Trust transformation team. NCEPOD clinical advisor/ambassador. Member of East Midlands Clinical Senate	

Name	Prof Edward Davis
I was appointed as a consultant orthopaedic surgeon at The Royal orthopaedic hospital in 2007 in the hip and knee arthroplasty unit. I undertake primary and revision hip and knee replacements at The Royal orthopaedic hospital and also have sessions at Russells Hall hospital in Dudley where I undertake primary joint replacements and undertake an on-call trauma commitment. I graduated from Birmingham University in 1996 and undertook my basic and higher surgical training in the West Midlands. I undertook a year's fellowship in revision hip and	

knee arthroplasty in Toronto, Canada.

I have an MSc in Trauma and a postgraduate certificate in medical education as well as the FRCS (Trauma and Orthopaedics). I have a keen interest in research and have a large research portfolio extending from drug treatments for osteoarthritis to the development of new surgical techniques, including computer navigation. I am the Director for Research and Development at The Royal Orthopaedic Hospital in Birmingham. I have been invited faculty at national and international meetings on hip and knee arthroplasty.

I am actively involved in education as an honorary Senior Clinical Lecturer and Senior Clinical Examiner at The University of Birmingham. I am also the Head of Academy at The Royal Orthopaedic Hospital co-ordinating all undergraduate medical education and the module lead for orthopaedics at the University of Birmingham.

I am married and enjoy spending my free time with my wife and 3 young children.

Name	Mr Duncan Learmonth
I have lived in the West Midlands since 1978 being a surgical trainee and consultant within the West Midlands area over the last 25 years. For a period of that time I have lived in the Barnt Green and Bromsgrove area and have used the Alexandra Hospital in the past. I have also visited the Alexandra and Worcester Hospitals for teaching and also visiting patients. I have also visited the Kidderminster Ambulatory Care Centre in the past.	

Name	Mr Athur Harikrishnan
Athur Harikrishnan is a consultant laparoscopic colorectal surgeon in Sheffield Teaching Hospitals. He trained in East Anglia and worked as a consultant in Doncaster for 4 years before moving to Sheffield in 2014. He is the Associate Training Programme Director for general surgery in the Yorkshire Deanery and holds an Honorary Clinical Senior Lecturership with Edge Hill University. His managerial roles include Yorkshire chapter representative of the Association of Coloproctology of GB & Ireland and member of the Yorkshire and Humber Clinical Senate.	

Name	Dr Andrew Phillips
	Unavailable

14 Appendix 3 Declaration of Interests

No declarations of interest were declared by the ICRT.

15 Appendix 4 ICRT Agenda Day 1

NHS England
West Midlands Clinical Senate

DAY 1

Independent Clinical Review Panel

Stage II Part B Clinical Assurance of the Future of Acute Hospital Services in Worcestershire Review

Thursday 21st April 2016, 10.00 am until 4.00 pm, Venue: Birmingham Research Park

PLEASE REPORT TO THE MAIN RECEPTION – YOU WILL THEN BE DIRECTED TO THE RELEVANT MEETING ROOMS

AGENDA

Item			Purpose
09:30		Arrival with Refreshments *(30 mins allocated)* Panel Pre-meet Helen Carter, Guy Daly and Clinical Senate Team	
10:00	1	Introduction by the Chair *(30 mins allocated)*	Introductions Housekeeping Declaration of Interest Review ToR
10:30	2	Programme Board Presentation and follow up Q&A *(1 hour 15 mins allocated)* (sponsoring organisation) Context and background Proposed Model of Care and how it meets the recommendations made by the West Midlands Clinical Senate previously The temporary emergency changes to services which have already been made	Commissioners presentation regarding context and background, proposed model of care and temporary emergency changes to services
11:45	3	Panel Discussion – Review of Documentation Submitted and Key Lines of Enquiry *(45 mins allocated)* *Think about further key questions for commissioners* Capturing the Changes: Develop a common understanding of the process and challenges to date	Overview of the documentation Explore and clarify specific issues Formulate questions for Commissioners
12:30		Lunch and Refreshments *(45 mins allocated)*	
1:15	4	Panel Discussion – Continuation Review of Documentation Submitted and Key Lines of Enquiry *(60 mins allocated)* *Think about further key questions for commissioners*	As above
2.15	5	Panel Questions to Sponsoring Organisation *(30 mins allocated)* *(sponsoring organisation)*	Explore and clarify any specific issues
2:45		Refreshments *(15 mins)*	
3:00	6	Panel Deliberations *(45 mins allocated)* Purpose:- 1. Assess Evidence Presented 2. Capture themes 3. Next Steps and Day 2	Assess, Agree, Capture, Next Steps
3:45	7	ICRT Chair and Vice Chair Debrief with Sponsoring Organisation *(15 mins allocated)*	Debrief
4:00		END	

16 Appendix 5 ICRT Agenda Day 2

NHS England
West Midlands Clinical Senate

DAY 2

Independent Clinical Review Panel

Stage II Part B Clinical Assurance of the Future of Acute Hospital Services in Worcestershire Review

Tuesday 3rd May 2016, 10.00 am until 4.00 pm

Venue – (AM) Alexandra Hospital, Woodrow Drive, Redditch, B58 7UB
(PM) Worcestershire Royal Hospital, Charles Hastings Way, Worcester, WR5 1DD

PLEASE REPORT TO THE MAIN RECEPTION AT ALEXANDRA HOSPITAL – YOU WILL THEN BE DIRECTED TO THE RELEVANT MEETING ROOMS

AGENDA

Item			Purpose
08:45		COACH TO BE BOOKED FROM BIRMINGHAM NEW STREET TO ALEXANDRA HOSPITAL	
09:30		Arrival with Refreshments *(30 mins allocated)* Panel Pre-meet Helen Carter, Guy Daly and Clinical Senate Team	
10:00	1	Welcome to Panel and Review of Day One *(20 mins allocated)* *(Alexandra)*	Introductions Housekeeping Declaration of Interest Review of Day 1
10:20	2	Tour of Alexandra Hospital *(60 mins allocated) (Alexandra)* (affected areas only) *(2 groups of 8 in parallel or 3 groups of 5)* Emergency Department Intensive Care Unit	Meet and discuss clinical engagement with clinical staff
11:20	3	Panel to Meet with Acute Medical Consultants *(40 mins allocated)* *(Alexandra)* Please note: timings may change to fit around the availability of the acute medical consultants (to meet either during tour of department or as a separate entity/meeting)	Meet and discuss clinical engagement with clinical staff
12:00	4	Reconvening of Panel *(30 mins allocated)* *(Alexandra)*	Feedback returned from panel to ICRT Chair
12:30	5	Lunch and Refreshments *(30 mins allocated) (Alexandra)*	
13:00	6	Travel to Worcestershire Royal Hospital *(40 mins allocated)* *(Minibus to be booked from Alexandra to WRH)*	
13:40	7	Tour of Worcestershire Royal Hospital *(90 mins allocated) (WRH)* *(affected services only)* *(3 groups of 5)* *Emergency Department and In-Patient Paediatrics* *Maternity Services* *Intensive Care Unit* *(both department and clinicians)*	Meet and discuss clinical engagement with clinical staff
15:10	8	Panel Questions to Sponsoring Organisation *(30 mins allocated) WRH)* *(sponsoring organisation)*	Explore and clarify any specific issues with sponsoring organisation
15:40	9	Reconvening of Panel for Deliberations (20 mins allocated) *(WRH)* Purpose:- 1. Assess Evidence Presented 2. Capture themes 3. Next Steps and Discuss Potential Day 3	Assess, Agree, Capture, Next Steps
16:00	10	ICRT Chair and Debrief with Sponsoring Organisation	Debrief
16:00		END – COACH TO BE BOOKED FROM WRH TO ALEX THEN TO BIRMINGHAM NEW STREET	

17 Appendix 6 ICRT Agenda Day 3

West Midlands Clinical Senate

DAY 3

Independent Clinical Review Panel

Stage II Part B Clinical Assurance of the Future of Acute Hospital Services in Worcestershire Review

Monday 16th May 2016, Venue: First Floor Meeting Rooms, The Rep Theatre, Broad Street, Birmingham

PLEASE REPORT TO THE MAIN RECEPTION – YOU WILL THEN BE DIRECTED TO THE RELEVANT MEETING ROOMS

AGENDA

Item			Purpose
09:30		Arrival with Refreshments *(30 mins allocated)* Panel Pre-meet Helen Carter, Guy Daly, Clinical Senate Team	
10:00	1	Introduction by the Chair	Introductions, housekeeping
West Midlands Ambulance Service Representatives in attendance throughout the day to answer questions			
10:15	2	• Panel Discussion – Review of Day Two • Scope of Terms of Reference • Key Lines of Enquiry • Further Documentation Submitted	Review ToR Overview of documentation Formulate questions / areas of clarification for Commissioners
11:00	3	Programme Board Follow up Q&A (sponsoring organisation)	Commissioners Q&A following Day Two
12:30		Lunch and Refreshments *(45 mins allocated)*	
1:15	4	Panel Discussion – Key Lines of Enquiry (with / without sponsoring organisation) – dependant on timings	Explore and clarify specific issues Formulate questions for Commissioners
2.15	5	Panel Questions to Programme Board (sponsoring organisation)	Explore and clarify specific issues
3:00		Refreshments *(15 mins allocated)*	
3:15	6	Panel Deliberations	Assess evidence presented, Agree, Capture themes, Next Steps
3:45	7	ICRT Chair, Vice Chair, Clinical Senate Team Debrief with Sponsoring Organisation Teleconferencing Details Dial In 0800 915 1950 or 0203 463 9697 Participant passcode: 47598189 then #	Debrief Report writing process

18 Appendix 7 Questions considered by the Panel outside of the scope of the Terms of Reference

West Midlands Clinical Senate
FoAHSW Review Stage II Part B
Comments / Questions from Panel Members post Day 2

Comment / Question	In/Out of ToR, which ToR objective plus related narrative
1. Perhaps as an aside or may be directly relevant, the key impression left with me is whether there are still real issues clinically (EM, Acute Medicine) or whether this is a cultural and leadership matter/challenge wherein some Trust staff are still on the old bus and have yet to get on the new one?	Out - cultural issue?
2. Terms of reference- ignoring medicine will be very artificial	Out - beyond remit
3. The team in Redditch seem to think that keeping children in Redditch was in their brief - is that correct? I cannot see how having an urgent care unit and an A&E in the same hospital with the same front door makes any sense. The public will never get this. It either has to be a minor injuries unit for all, an adult A&E (but with limited opening hours) or a GP-referred urgent care unit, but not a mix.	In Ob 4 - need to think about public messaging
4. Children cannot come to Redditch A&E - the numbers will be small, and the staff will de-skill no matter how well trained	In Ob 4 - need to think about public messaging
5. How many medical admissions are there in Redditch? How does this compare with say 5 years ago? Your quote "95% of patients will still go to Redditch" - who are they and what is the 5% that does not? Does that include maternity etc, as these changes have been made	Out - medical admissions are not an objective
6. What are the HSMR/SHMI figures for Worcester hospital and Redditch overall and for strokes, MI's and all medicine admissions? - what are the length of stay figures for the same patients? Are the "Worcester only" gastro jobs just an oversight or a deliberate policy by Worcester medicine?	In? - tricky as the stats are a proxy for care but relate to whole hosp? good to have data
7. I think we should have an acute hospital Worcester; a day case hospital Kidderminster and an elective hospital in Redditch. Can you do the maths to see how that works?	Out - an opinion not an objective?
8. Ambulance Query; This may be outside of the review. I'm seeking a clear justification for another ambulance crew -there is a lot of information but we have to work out for the justification. The majority of calls are for slips, trips and falls so, as in other Areas, establish a falls team to enable people being treated at home and avoiding going to Hospital. In other words, I suggest that this should give them an opportunity to review their system especially as patients will be going to the Alex as opposed to the Royal	Out - refer to evidence by sponsors

9. Transport Query; I am still concerned about the 15% who do not have cars. Is the Hospital Shuttle going to continue? Cost of parking is an issue will there be dispensation for those who travel? From observation parking spaces will be an issue for a long time. Relying on the extension of the bus is not going to be viable. The Local Authority will say it is a NHS issue and the NHS will say it is a Local Authority issue, i.e who pays. Is the Trust going to pump fund community travel organisations? Can volunteering be developed to transport patients? There needs to be a clear strategy as especially from the focus groups the major concern is transport. It would be better for consultation to say that this is what we are going to do and not we are hoping to happen.	Out - refer to evidence from sponsors
10. Overnight Stay Query; Did we review the availability of parents/partners staying overnight at the Royal? How many positions are there and what happens if they are full?	Out - beyond remit
11. Concerns around staffing	In Ob 3
12. Paediatrics - what is length of stay for admissions at Worcester & is this in line with other Paediatric units? Will they provide consultant support to Alexandra Hospital? What provisions for child safe guarding when the co-located primary care unit closes at Alexandra?	In Ob 2
13. Emergency Medicine - ED consultants at Worcester don't wish to provide support / cover to Alexandra. Have the ED physicians 'bought' into the Trust strategic vision? Ability to recruit & retain middle grade & consultants into ED?	In Ob 2
14. Ambulatory medicine - why are there different ambulatory pathways into Alexandra & Worcester Hospitals? Some managed by acute medicine & some by emergency medicine? Duplication of processes	In Ob 2
15. Why different 'observation' facilities at Alexandra - one managed by acute medicine & one by emergency medicine? Duplication of processes	In Ob 2
16. The co-located primary care unit - why do they wish to perform investigations if they are providing primary care? This should be done by the ED (duplication / waste of resources)	In? Ob2
17. Processes for inter-facility need to be robust & funding for additional vehicles for WMAS must be secured	Out? - refer to evidence by sponsors
18. Additional bed capacity appears lacking at Worcester? Insufficient parking facilities at Worcester site	In? Ob 2?
19. Road signage needs to reflect only adult unit at Alexandra	In Ob 4 - possibly already covered by sponsors evidence
20. The AH site Operating Model for AH could potentially miss the opportunity of increased flow by adopting its planned triage step and not 'stream-lining' the front of ED.	In Ob3
21. The transfer of sub-specialties from AH has the potential to render the proposed service not viable because of the mitigation of risk response to the shift in Paediatrics to WRH. This is further undermined by the instability in the Acute Medical Team at AH.	In Obs 2, 3 & 4

22. The communications Strategy to inform customers of the changes to service provision will have to be extremely effective to mitigate the political backlash and to change their behaviours when choosing to access urgent and emergency care. There is some evidence that the current engagement Strategy has been ineffective in providing Trust Staff with confidence.	In Ob 4 - need to think about public messaging
23. There is a significant challenge in providing sufficient workforce in a broad swathe of specialties and skill-sets to be in a position to deliver FoAHSW, notwithstanding the need for seven-day services in the future.	Out? - general statement
24. The shift of clinical cover to WRH appears to generate the need for additional beds. The level of additional bed provision (80-160) is not convincing because the evidence and analysis is lacking and vague.	In? Ob 3 & 5
25. The description of Countywide services, and by implication; the requirement for under-resourced teams to provide flexible cross-site cover, appears to need further work-up and modelling. As a solution it is not supported by many of the Medical Consultants	In? Ob 3 & 5

Produced by:
West Midlands Clinical Senate
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Email: england.wmcs@nhs.net
Date: June 2016