East Midlands Clinical Senate

Resetting Health Care in Corby

Report of the Independent Clinical Senate Review Panel (31st October 2017)

December 2017

england.eastmidlandsclinicalsenate@nhs.net

GLOSSARY OF ABBREVIATIONS USED IN THE REPORT

STP	Sustainability and Transformation Partnerships
CCG	Clinical Commissioning Group
APMS	Alternative Provider Medical Services
IUC CAS	Integrated Urgent Care Clinical Assessment Service
DoS	Directory of Services
UCC	Urgent Care Centre
A&E	Accident & Emergency
JSNA	Joint Strategic Needs Assessment
GPFV	General Practice Forward View
AHSN	Academic Health Science Network
DOI	Declarations of Interest
PPI	Patient Participation Involvement

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Foreword by Clinical Senate co-chair

The NHS and local authorities are facing unprecedented challenges, and the role of Clinical Senates in providing independent clinical advice to commissioners and local health systems (STPs) will be more important than ever.

The major national policy directive for the NHS is Sustainability and Transformation Partnerships, and the formulation of long term plans that bring together health and social care. Each area has developed proposals built around the needs of the whole population, not just those of individual organisations.

Primary Care and Urgent and Emergency Care are two of the NHS's four priorities, as set out in the Five Year Forward View.

One of Northamptonshire STP's priorities is: Making sure that people are able to access the right care when they need it, in primary, community and urgent/emergency care services. Corby CCG in its case for change is aligned to this priority.

Clinical Senates have a unique role within health and care, and our aim in this review was to provide independent clinical advice where a patient voice is on a par with clinicians. Additionally, to make recommendations to Corby CCG to enable them to move forward positively to public consultation, with a new model of care that is based on sound clinical evidence and will improve patient experience of NHS services.

We thank Corby CCG for asking the Clinical Senate to undertake the review and for providing us with the information to enable us to make constructive recommendations.

I wish to thank all of our panel members for giving up their time and their attention to this review. The panel discussions were open, balanced, and constructive, and conducted in a professional manner. It was a pleasure to chair such an experienced, engaged, and motivated group of clinicians and patient representatives.

On behalf of the panel and the Clinical Senate, we look forward to assisting Corby CCG in the future.

Dr Neill Hepburn

East Midlands Clinical Senate co-chair

1 CLINICAL SENATE CO-CHAIR SUMMARY AND KEY RECOMMENDATIONS

The Clinical Senate was asked by the sponsoring organisation to consider the following:

1. The current model has its viability reduced because it has no clinical filter

2. To review the 2 proposed options:
    - Option 1: NHS 111 clinically triaged entry to an Urgent Care Service which has 88% activity planned into an APMS contract and 12% activity paid for at A&E Type 3 tariff
    - Option 2: NHS 111/Primary care triaged model which comprises extended hours primary care and enhanced delivery primary care which supports delivery for minor injuries, “hot paediatrics” and diagnostics

3. To agree that the 2 options are ready for patient, public and stakeholder consultation

The panel agreed that a clinically, or appropriately, triaged model, as a concept, is reasonable. However, the panel had concerns regarding the NHS 111 (triage/navigator) service that is proposed.

Specifically addressing the issues above:

1. The panel agreed with point (statement) 1. The current model (UCC) can be accessed by walking in – a patient does not require a booked appointment and it can be accessed without needing to go through a triage/navigator system. It was recognised that Corby CCG is an outlier in that the UCC do not apply any filter criteria to the service provided, i.e. they are not streaming patients upon arrival. UCCs usually have the remit to re-orientate non-urgent work back to primary care.

2. The panel was agreed that there is insufficient resource (clinical workforce) to sustain the current model – referring to the uncapped cost to Corby CCG.

3. The panel considered the 2 options and agreed that insufficient work had been undertaken to develop a navigation system. This issue was two-fold: a distinction had not been made between NHS 111 and a primary care triage service model. It was agreed that NHS 111 is not the right system to use as the patient navigator (in part due to capacity and in part due to the granular local knowledge required).

The current configuration and professional staffing of NHS 111 has the capability to receive demographics, but Pathways is not sufficiently sophisticated to provide the level of clinical assessment, advice and direction required to ensure timely, locally-tailored navigation outside of Pathways and the DoS. NHS 111 functions at scale and cannot differentiate outside of the DoS by location, i.e. call advisers/clinical advisers cannot be relied upon to "know" a local variation that is not returned by the DoS following Pathways. Whilst the proposals are concerned with unscheduled access to primary care provision within Corby, the plans should be aligned with commissioning intentions with regard to the provision of an IUC Clinical Assessment Service (CAS) in accordance with the national IUC Service Specification (NHS England, August 2017).

Whilst it is recommended that IUC commissioning be done "at scale" (suggesting 1 million population) beyond the initial call-handling and advice provided within NHS 111 and Pathways (or its equivalent), the configuration of the CAS (which may be virtual) is intended to be based around natural populations and primary care services which would provide both the local knowledge of services and the level of clinical expertise and autonomy not available at the scale within the NHS 111 provider.

Therefore, Corby practices and the unscheduled or urgent care service would be ideally placed to form a part of the IUC CAS (which is likely to be commissioned on a larger footprint) and consideration should be given to its functional integration through information and communication links, making best use of local clinical capacity, reducing duplication of effort/resourcing and avoid creating multiple points of access.

Essentially, the introduction of an IUC CAS will fundamentally change the way patients access health services. It will mean patients will receive a complete episode of care concluding with either: advice, a prescription, or an appointment for further

assessment or treatment. It should negate the need for additional signposting or onward referral to secondary care[1].

The panel also expressed concerns around understanding the demographics of the population accessing the service.

The panel unanimously agreed that the 2 models are not ready for public consultation at this moment in time.

It was agreed by both the panel and the sponsoring organisation that a teleconference call in about 6 weeks' time (from the panel date) would be scheduled; to review the progress specifically around a local patient navigator solution. This would not require the full original panel, only those individuals with particular knowledge and expertise.

Full numbered recommendations are outlined below under conclusions and advice.

The addendum relating to the follow up teleconference call can be read in full at the end of the report. The panel accepted the additional evidence and confirmed that this analysis had addressed the issues posed by the original panel.

It was agreed that Corby CCG is now ready to go out to consultation.

[1] Integrated Urgent Care Service Specification (NHS England August 2017)

2 BACKGROUND AND ADVICE REQUEST - NEW PRIMARY CARE CLINICAL MODEL REVIEW

2.1 Description of current service model[2]

Corby CCG consists of five member practices and covering a practice population of 76,785. Corby Urgent Care Centre opened in 2012. It consolidated several services providing urgent care solutions into one place and was commissioned on the premise that it would reduce the overall spend on urgent care in Corby. The commissioned service model provides direct access for undifferentiated patients requiring urgent care. Patients presenting at the UCC are categorised into one of 5 clinical categories, from: category 1 (immediate resuscitation) to: category 5 (non-urgent). The UCC does not have the rights to make elective referrals for acute care intervention.

2.2 Case for change[3]

Corby CCG states in their supporting evidence that activity at the UCC is high. Compared to its peers, NHS Corby is an outlier for combined A&E and UCC attendance. Analysis of the UCC activity (by the sponsoring organisation) stated that 88% of activity are presentations which should be routinely dealt with in primary care. Corby CCG has concluded that the current model poses two issues to the local system: it is financially unsustainable for the health system, as A&E type 3 tariff is paid and it is not resolving the growth in demand challenge that the system faces.

2.3 Scope and limitations of review

Two clinically viable and financially affordable service model options have been proposed by Corby CCG. The Clinical Senate was asked to review the proposed options (1 and 2) and agree if they are ready for patient, public and stakeholder consultation. The options were seemingly revised from the original terms of reference (appendix 1), which had included a status quo option (continue with the UCC), and an alternative care model which proposed improving primary care access by extending the hours of and enhancing primary care services.

Urgent Treatment Centres were out of scope of the review, and whilst the sponsoring organisation had determined that the current UCC model is financially unsustainable,

[2] Extracted from the document Resetting Health Care in Corby The Evidence for Change NHS Corby CCG October 2017
[3] As above

the role of the Senate was to only consider clinical viability of the two options presented.

3 METHODOLOGY AND GOVERNANCE

3.1 Details of approach taken

The sponsoring organisation engaged with the Clinical Senate on 20th September 2017. It was agreed that a half a day panel in Corby would be held on 31st October. Due to the pressurised timeline, panel members were identified as early as possible from within and outside of the East Midlands Clinical Senate, and patient representatives (experts by experience) were identified by AHSN (appendix 2).

Due to the sensitive nature of the review and to be cognisant of the local judicial issues, potential conflicts of interest were considered, and a number of experienced health professionals were excluded to ensure that the Clinical Senate's advice remained independent and impartial.

3.2 Documents used

Supporting evidence was submitted by the sponsoring organisation and disseminated to panel members on 19th October. The pre-reading included:

- A presentation that summarised the options and the evidence paper
- The final master evidence pack (The Evidence for Change)

A pre-panel teleconference call was held on 20th October (appendix 3), following which, further supporting information was requested by the panel – in order to be able to fully address the questions in the Terms of Reference. This was received and disseminated on 26th October, and included:

- Clinical risk assessment
- Mitigation analysis regarding A&E attendance
- Local Authority JSNA
- Corby UCC attendance per locality

Background information was also provided:

- GPFV (NHS England April 2016)
- 2016/17 General Medical Services (GMS) contract
- Integrated Urgent Care Service Specification (NHS England August 2017)
- A CQC Emergency Care Survey

A draft report was sent to the panel members and the sponsoring organisation to check for matters of accuracy.

The final report was submitted to the Senate Council (and ratified on 5th December) for it to ensure that the clinical review panel met and fulfilled the revised options and the statement that further clarified what the sponsoring organisation was asking the Clinical Senate members to consider.

This report was then submitted to the sponsoring organisation, Corby CCG, on 8th December 2017 (an extension to the timeline was agreed with Corby CCG in order to be able to incorporate the addendum).

East Midlands Clinical Senate will publish this report on its website as agreed with the sponsoring organisation, Corby CCG, in the Terms of Reference.

4 CONCLUSIONS AND ADVICE

It was agreed that the concept of clinically or appropriately triaging patients is reasonable, and that work would already be underway by commissioners to align services as described in NHS England documents, for example: Improving access for all: reducing inequalities in access to general practice services (July 2017) and Integrated Urgent Care Service Specification (August 2017). The panel, therefore, did not have any concerns with the proposal to clinically assess and direct patients to an appropriate clinical service as part of extended primary care access.

The panel recommended Corby CCG give further consideration to consulting with the public on 2 options, as this could be perceived as confusing. The Chair reflected that Corby CCG considers it is on a journey from option 1 to option 2, and therefore Corby CCG might want to consider articulating this journey as part of their consultation.

The major concern for the panel was that NHS 111 is not the right system to use as the patient navigator for the proposed service model (s). Detailed local knowledge of services and the population is needed for this to work effectively – the panel did not consider that Corby CCG has a sufficiently detailed understanding of the patients who were accessing the current service and therefore could not provide assurance that their needs would be met by the new service.

The panel concluded that a clear description of the navigation system is required before the panel considers the options would be ready for public consultation.

It was agreed that a smaller panel will reconvene on a teleconference call in about 6 weeks' time to review the patient navigator options, which will be submitted by the sponsoring organisation in advance.

An addendum to this report will be provided subsequent to the conclusion of this teleconference panel.

4.1 Recommendations

4.1.1 Recommendation 1

The panel recommended that Corby CCG consult on a single model. The public consultation should clearly articulate the eventual clinical model (option 2) and set out how it intends to phase implementation from option 1 to option 2.

4.1.2 Recommendation 2

That Corby CCG provides a clear narrative for a patient navigator system (i.e. what is navigation; how will it be delivered; where will the clinical assessment take place) to support their clinical model, recognising that a local problem requires a local solution and that NHS 111 is not considered by the panel to be the right system.

4.1.3 Recommendation 3

That a clear description of a local patient navigation system is cognisant of the people using the service and fully addresses any inequalities issues regarding access and demographics.

The panel were particularly concerned that no data had been presented for the current users of the service by deprivation quintile, to understand how changes may disproportionately affect the most deprived population. Similarly, the panel felt it would be helpful for the CCG to demonstrate further insight into the group of patients classified as having 'no clinical need', which comprised approximately a quarter of patients using the current service. The panel were mindful of the need to articulate where possible important inequalities within this group to understand the impact on the proposed new services. This should reference to the mental health needs which the panel felt may be important drivers of inequalities and therefore require specific planning to address in the context of the new model.

4.1.4 Recommendation 4

That a further smaller panel is convened by teleconference to review progress against recommendations 2 and 3 concerning the navigation system – this was agreed on 31st October.

4.1.5 Recommendation 5

The panel unanimously agreed that the sponsoring organisation is not ready for public consultation until the patient navigation system and inequalities issues are adequately addressed.

5 ADDENDUM

The teleconference took place as agreed on 4th December (participant details contained in Appendix 2).

The panel were pleased to see the additional analysis and audit, which helped the Clinical Senate to better understand the cohort of patients currently using the UCC.

It was accepted that the further analysis had made it clear to the panel, that extended general practice will go a long way to address the clinical need for this cohort of patients – rather than patients being seen (and treated) in urgent care.

Corby CCG outlined their patient navigator system that navigates local provision, and they confirmed that training of both (GP practice) clinical and non-clinical staff is now complete.

The panel unanimously agreed that the navigation system has now been made clear through the additional analysis of service use: the activity is largely core primary care.

The proposal also fully reflects the GP Five Year Forward View.

The panel confirmed that it now accepted the evidence provided by Corby CCG which had addressed the questions posed by the Independent Clinical Senate Review Panel on 31st October and outlined in this subsequent report.

The panel confirmed that Corby CCG had demonstrated further insight into the group of patients classified as having 'no clinical need', and had addressed the issues relating to potential inequalities. However, the panel did recommend that Corby CCG is able to articulate in writing that there will not be a disproportionate impact on Corby's most deprived communities by withdrawing the UCC facility. It was suggested that the cohort of patients currently accessing the UCC is mapped across deprivation quintiles and triangulated with the local deprivation profile, as presented in the panel documentation.

The panel was content that a clear narrative had now been provided for the patient navigator system and that the consultation message had been simplified. The panel

did recommend that the pictorial representation could be simplified even further. It was suggested that Corby CCG consider the following points:

- Remove the walk in element (because a patient will not be able to walk into the UCC once the new model of care has been adopted)
- Simplify the message to the public – call your usual GP number
- A patient will be seen in their usual GP practice or at the Hub
- Need to clarify what happens at 6.30pm when most GP practices close for the day
- Remove both arrows from the proposed New Care Model – Corby View, as it might give the impression that a patient still has two choices. Reduce to one arrow, and be explicit that onward referral may be appropriate for paediatrics, minor injuries, diagnostics.

It was agreed that Corby CCG is now ready to go out to consultation, as the case for change is understood.

By way of a footnote, and to reflect the panel advice provided throughout this process. The panel acknowledged that NHS 111 is the aspirational single point of access for unscheduled primary care 24/7; however, it is not currently the norm for in-hours access to GPs. The model proposed by Corby CCG is to retain existing GP access numbers for registered patients rather than replace with a single point of access, which was viewed favourably by the panel.

It would be extremely difficult currently for NHS 111 to identify registered Corby GP patients and provide bespoke assessment or advice for them with the current five counties call handling configuration.

NHS 111 is limited to using Pathways assessments and then a corresponding DoS outcome. Therefore, putting calls through to 111 at this stage (and the panel recognised that Corby CCG is seeking a more immediate solution) would not be per navigation criteria and potentially would result in higher A&E and 999 dispositions.

Finally, this model does not preclude the move to NHS 111 as the single point of access in the future, should that be a desirable solution for Corby CCG.

Appendix 1 – Terms of Reference

CLINICAL REVIEW: TERMS OF REFERENCE

Title: New Primary Care Clinical Model Review

Sponsoring Organisation: Corby CCG

Clinical Senate: East Midlands

NHS England regional or area team: Midlands & East/ Central Midlands DCO

Terms of reference agreed by:

Name: N Hepburn/ E Orrock **on behalf of Clinical Senate and**

Name: C Dehghani/ B Grobet **on behalf of sponsoring organisation**

Date: 19th October 2017

Clinical review team members

Chair: Dr Neill Hepburn, Clinical Senate co-chair

Panel members:

Name	Role	Organisation
Edd Wallis	Chief Physiologist	United Lincolnshire Hospitals Trust
Ian Mursell	Consultant Paramedic	East Midlands Ambulance Service (tentative)
Mangesh Marudkar	Consultant Psychiatrist for Older Adults	Glenfield Hospital
Ant Rosevear	Assistant COO	Sherwood Forest Hospitals Trust
Matt Day	Consultant	Public Health England
Brian Rowlands	Emeritus Professor of Surgery	University of Nottingham
Molla Imaduddin Ahmed	ST7 Paediatrics	Health Education East

		Midlands
Liz Marder	Consultant Paediatrician	Nottingham University Hospitals Trust
Nabeel Alsindi	GP & Clinical Lead for Primary Care and Long Term Conditions	NHS Doncaster Clinical Commissioning Group (ad-hoc services provided by Yorkshire & Humber Clinical Senate)
Mark Russell	Patient representative	Academic Health Science Network (AHSN) PPI Senate
Susan Edge	Patient representative	Academic Health Science Network (AHSN) PPI Senate
Simon Browes	Independent Nurse Consultant	Urgent & Emergency Care Partnership / Nottinghamshire STP Workforce Transformation Programme

Aims and objectives of the clinical review

The aim of the clinical review is to test if there is a clear clinical evidence base underpinning the proposals and to provide an independent clinical view on the equity, quality in access of the New Primary Care Clinical Model and whether the proposal answers the question of safe disposal of 76,066 spells of urgent care under discussion.

Corby CCG currently commissions an Urgent Care Centre which is open from 8am-8pm 7 days per week. The case for change and supporting evidence will show that 88% of patients accessing the Urgent Care Centre could have been appropriately seen in a consultation in Primary Care (option 1 below). GP practices are paid by the CCG per patient registered with their practice. The CCG are paying twice for patients that could have been appropriately seen in Primary Care (under a GMS contract)

although instead are accessing the Urgent Care Centre for minor illnesses (each individual spell at UCC is at tariff cost).

Corby CCG are therefore proposing an alternative care model (option 2 below) to address this issue by improving Primary Care access – by extending the hours of Primary Care and enhancing services operating from local hubs with a more selective range of services than the services provided by the Urgent Care Centre – which has been determined by a gap analysis.

Scope of the review

Review the options available to move to a future model of care and the process of identification of a preferred clinical option to be considered as part of the planned patient, public and stakeholder consultation

Option 1: Continue with the Urgent Care Centre - at national tariff rates

Option 2: Provide increased access hubs for primary care, open from 8am – 8pm, 7 days per week and provide the following services:

- Navigation Right Care, First Time
- Primary care extended access for minor illness
- Primary care enhanced access for minor illness
- Minor Injuries
- Paediatric hot clinics
- Diagnostics

Out of scope:

- Urgent Treatment Centres

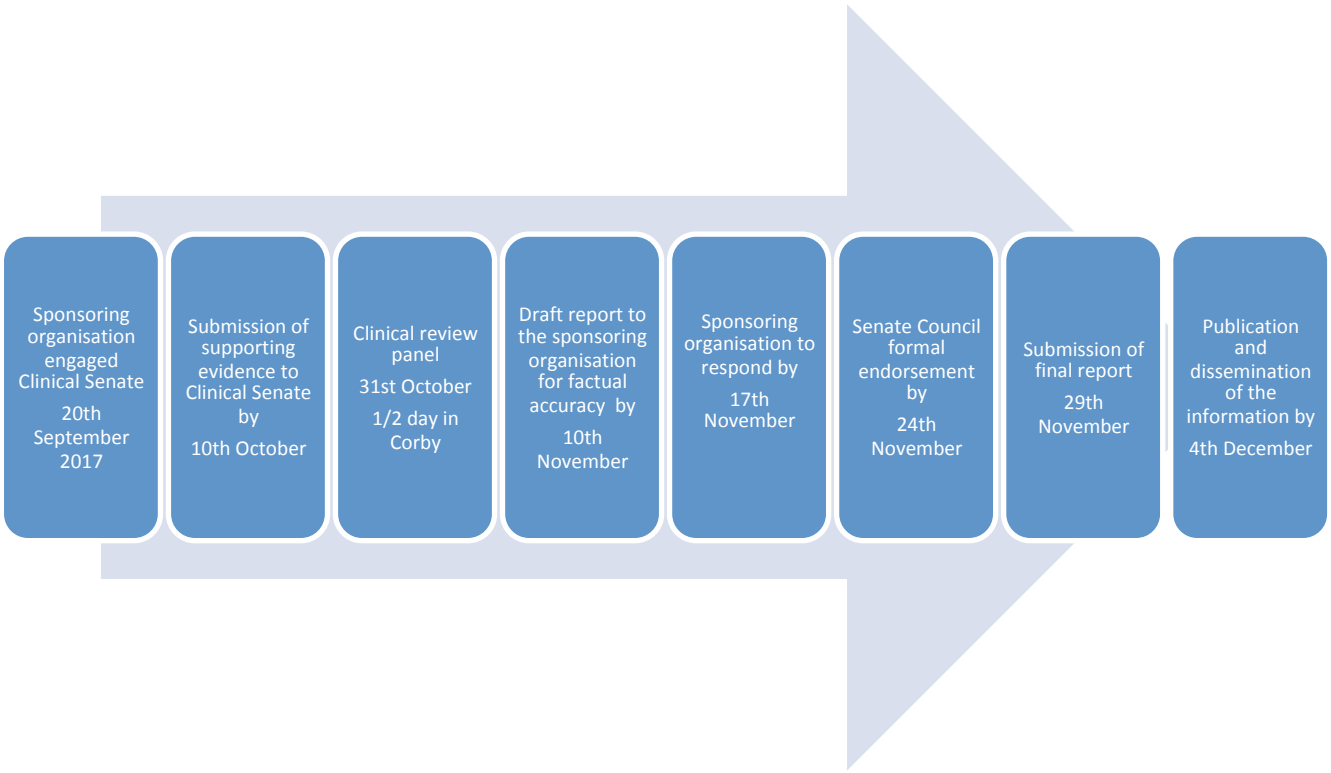
When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality)?

- Is there evidence that the proposals will improve the quality, safety and sustainability of care?
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Do the proposals reflect the goals of the NHS Outcomes Framework?
- Do the proposals reflect the rights and pledges in the NHS Constitution?
- Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?
- Do the proposals meet the current and future healthcare needs of their patients?
- Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline



Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The sponsoring organisation has agreed to collate and provide the following supporting information:

- All background review information (i.e. stakeholder workshops; Healthwatch 2015 Urgent Care Review; NHS Survey results; current model activity and current workforce numbers; Equality Impact Assessment)
- Patient, Public and Stakeholder Engagement paper and timeline
- Case for Change
- Evidence base (national drivers; best practice)

- New clinical model for Primary Care presentation (including patient pathway examples, activity and workforce numbers, key mobilisation milestones for extended primary care, risks and issues log)
- Gaps/risks related to gaps/mitigation
- PID development alongside the Clinical Review and Consultation period

The Clinical Review will consist of a face-to-face review panel with a presentation from Corby CCG.

Report

A draft clinical senate assurance report will be circulated within 8 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking.

Comments/ corrections must be received within a further 5 working days.

The final report will be submitted to the sponsoring organisation by 29th November.

Communication and media handling

Dates and arrangements for publication and dissemination of report and associated information: To include identified lead person, where report will be published, press releases/conferences, meetings with patient groups, public, staff and boards, health and wellbeing boards and Health overview and scrutiny committees.

Resources

The East Midlands clinical senate will provide administrative support to the review team, including setting up the meetings, taking minutes 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.

Accountability and Governance

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

The East Midlands clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

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

Functions, responsibilities and roles

The **sponsoring organisation** will

- provide the clinical review panel with 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 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 matters 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

Clinical senate council and the sponsoring organisation 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 and
- provide suitable support to the team

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 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

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 or 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 which may materialise during the review

Appendix 2 – Clinical review team members and their biographies, and any declarations of interest

Name	Role	Organisation	DOI	Y/N Participated in follow up teleconference call
Dr Neill Hepburn	Co-chair East Midlands Clinical Senate	United Lincolnshire Hospitals NHS Trust	None	Y
Mr Edd Wallis	Chief Physiologist	United Lincolnshire Hospitals NHS Trust	Honorary contract of employment at Kettering General Hospital	N
Dr Mangesh Marudkar	Consultant Psychiatrist for Older Adults	Glenfield Hospital	None	N
Mr Matt Day	Consultant	Public Health England	None	Y
Dr Molla Imaduddin Ahmed	ST7 Paediatrics	Health Education East Midlands	None	N
Dr Liz Marder	Consultant Paediatrician	Nottingham University Hospitals Trust	None	N
Dr Nabeel Alsindi	GP & Clinical Lead for Primary Care and Long Term Conditions	NHS Doncaster Clinical Commissioning Group (ad-hoc	None	N

		services provided by Yorkshire & Humber Clinical Senate)		
Mr Mark Russell	Patient representative	Academic Health Science Network (AHSN) PPI Senate	None	Y
Ms Susan Edge	Patient representative	Academic Health Science Network (AHSN) PPI Senate	Lay member PIPE LWCCG Lay partner HEE East Midlands PP panel member NIHR	N
Mr Simon Browes	Independent Nurse Consultant	Urgent & Emergency Care Partnership / Nottinghamshire STP Workforce Transformation Programme	None	Y

Clinical Senate Support Team

Ms Emma Orrock – Head of East Midlands Clinical Senate, NHS England (participated in follow up teleconference call)

Ms Sheila Darji – Senate Administrator & Project Officer, NHS England

Biographies

Dr Neill Hepburn MBA MD FRCP

Neill is a Consultant Dermatologist and the Medical Director at United Lincolnshire Hospitals NHS Trust. Neill qualified from Manchester University in 1984 and trained in dermatology in the Army and at the Edinburgh Royal Infirmary during which time he was awarded the MD for his work on leishmaniasis. As an Army doctor he saw active service in Northern Ireland, First Gulf War and with the United Nations in Angola. Arriving in Lincoln in 1997 he set up the 'hub and spoke' dermatology service for Lincolnshire. As Clinical Director for Medical Specialties he integrated the separate services across the county. Neill was appointed as the Deputy Medical Director in 2012 with particular responsibly for appraisal, revalidation and professional standards.

Mr Edd Wallis

Edd is currently working as chief physiologist at United Lincolnshire Hospitals NHS Trust and honorary chief physiologist at Kettering General Hospital NHS Trust. Edd has a special interest in complex implantable cardiac devices holding international professional accreditation from the European Society of Cardiology. Edd has also recently been awarded chartered scientist status by the United Kingdom Science Council and holds full membership with the Society of Cardiological Science and Technology and the Society of Critical Care Technology. A graduate of the NHS Leadership Academy, Edd holds a postgraduate certificate in healthcare leadership following a successful project in clinical service redesign and organisational development.

Edd is a professional assessor with the Academy of Healthcare Science and a training officer with the National School of Healthcare Science with extensive experience teaching and assessing both undergraduate and post graduate healthcare science students. Edd also has 6 years' experience working as a volunteer critical care technician with L.I.V.E.S providing expert pre-hospital medical support to the local ambulance service and is a certified advanced life support provider with the Resus Council UK.

Dr Mangesh Marudkar MBBS, MD, DNBE MRCPsych, PhD

Mangesh is a Consultant Psychiatrist for Older Adults in Leicestershire since 2001. Mangesh is also an Executive Committee member of the Faculty of Old Age Psychiatry (Royal College of Psychiatrists) since June 2014. Mangesh was formerly the Associate Medical Director (Medical Education) at the Leicestershire Partnership NHS Trust (2009 - 2013) and the Postgraduate Course Organiser (2002-2009).

Mr Matt Day FFPH

Matt provides public health leadership to the NHS through his current and previous role. Matt served as vice-chair of the national specialised commissioning network and led for PHE on NHS clinical policy in cancer and mental health initiating and chairing the first ever national prevention reviews for specialised mental health on smoking, CAHMS, obesity, and new psychoactive substances. Locally he is leading on service reconfiguration work for the Clinical Senate and STP leaders, and manages a team responsible for public health screening, dental public health, and specialised services advice to the NHS. Matt has published extensively on cancer and public health leadership and workforce. Matt has recently been appointed as a member of the national ACRA Technical Advisory Group, which advises Ministers on health resource allocation.

Dr Molla Imaduddin Ahmed

Specialist Registrar Paediatrics

Molla (Imad) is a paediatric registrar at Health Education East Midlands, currently working at Peterborough City Hospital. Imad represented the trainees from East Midlands on the RCPCH trainees committee (2014-2017), which works on matters of relevance to trainees nationally. Imad is a fellow of the Royal Society of Public Health and has been awarded “certificated change agent’ by Horizons group at NHS quality and School for healthcare radicals. Imad chaired the East Midlands Trainees group on quality assessment of postgraduate training and the East Midlands (South) Paediatric ST4-8 trainees committee.

Imad is a member of the East Midlands Children’s Clinical steering group and was a member of the East Midlands Clinical Senate panel conducting an independent review of health and social care in Lincolnshire (June 2014), vascular services in

Hertfordshire and Essex (December 2014) and Leicestershire Better Care Together programme (August 2015).

Dr Liz Marder FRCPCH

Liz's clinical work is in inner city Nottingham and includes general paediatrics in the community, including safeguarding and with special interests in Neurodisability, running specialist services for Down syndrome and autism spectrum disorder. Within the Trust Liz held the post of pathway lead clinician for 8 years, and was involved with the Trust service improvement programme, and ensuring quality, risk and safety for children and young people across the organisation. Liz has been on the Trust information governance, clinical effectiveness, clinical ICT, safeguarding and clinical ethics committees.

Liz has wide experience in local and regional strategic development and was clinical lead for the Children's work stream of the Nottinghamshire (Darzi) next stage review and the Nottinghamshire Children's Health Network. Liz is on the Greater Nottingham Health & Care Partners - Mother's Children & Young People work stream, and is a member of the East Midlands Clinical Senate Council. Liz is a member of the Royal College of Paediatrics and Child Health Paediatricians in Medical Management Committee, and is on the panel for the college Invited Reviews Programme.

Liz is a founder and past Chairperson of the Down syndrome medical interest group (UK and Ireland), and is currently web editor for www.dsmig.org.uk. Liz regularly lectures, and writes on medical aspects of Down syndrome for parents and professionals and is co-editor of the book "Down syndrome – current perspectives".

Dr Nabeel Alsindi

Nabeel is the Clinical Lead for Primary Care and Long Term Conditions, NHS Doncaster CCG. Following on from his successful 1 year Commissioning Fellowship at the end of his GP training, Nabeel was appointed to this newly-created post in August 2015. Nabeel works at the CCG for 3 days a week, working closely with the Chief of Partnerships Commissioning & Primary Care and the rest of the Primary Care Team in developing and implementing their Primary Care Strategy, engaging

with their practices and system partners, and providing Primary Care input to different pieces of work across the CCG. Nabeel also leads on Respiratory for the CCG.

Nabeel has been at Bentley Surgery in Doncaster since September, working 2 days a week at a progressive practice in a former mining village with a high level of deprivation.

Mr Mark Russell

Mark is a patient and carer, currently co-chair of the East Midlands PPI Senate and lives in Nottinghamshire. He was previously a patient rep for Nottinghamshire West CCG and current lay member for Bassetlaw CCG where he chairs various governance committees. He also chairs his local Patient Participation Group.

Ms Susan Edge

Susan is a patient, member of the East Midlands PPI Senate and lives in Lincolnshire. Susan is a lay member for Lincolnshire West CCG where she chairs various governance committees. Susan is also a lay partner for Health Education England – East Midlands.

Mr Simon Browes

Simon is an experienced healthcare system leader with a strong, diverse professional background in primary and community healthcare, clinical-academic practice and the strategic leadership and development of hospital, community and integrated health services. Simon provides a range of practical solutions, advice and support to the healthcare sector. Simon is a Consultant Nurse Practitioner, Specialist Community Public Health Nurse, and an alumnus of the world-leading NHS Graduate Scheme. Simon is passionate about evidence-based healthcare and practice development, and has held senior positions in the UK and New Zealand, with a track record of innovative health care practice, workforce development and professional leadership at organisational, regional and national levels.

With firm foundations in clinical practice, Simon has progressed to become a consultant clinician and board-level executive with a strong focus on delivering strategic clinical quality and system transformation.

Appendix 3 – Pre-panel teleconference call

Corby Review: Call with panel members
20th October 2017 1.30pm-2.30pm
Teleconference

	Name:	Job Title/ Organisation
Present:	Neill Hepburn (NH) (Chair)	Consultant Dermatologist & Medical Director United Lincolnshire Hospitals NHS Trust
	Emma Orrock (EO)	Head of Clinical Senate NHS England
	Mark Russell (MR)	Patient representative Academic Health Science Network (AHSN) PPI Senate
	Matt Day (MD)	Consultant Public Health England PHE
	Ian Mursell (IM)	Consultant Paramedic East Midlands Ambulance Service (EMAS)
	Mangesh Marudkar (MM)	Consultant Psychiatrist for Older Adults Glenfield Hospital (UHL)
	Sheila Darji (SD)	Clinical Senate PA & Project Officer NHS England
Apologies	Edd Wallis (EW)	Chief Physiologist United Lincolnshire Hospitals Trust
	Ant Rosevear (AR)	Assistant COO Sherwood Forest Hospitals Trust
	Brian Rowlands (BR)	Emeritus Professor of Surgery University of Nottingham
	Imad Ahmed (IA)	ST7 Paediatrics Health Education East Midlands
	Liz Marder (LM)	Consultant Paediatrician Nottingham University Hospitals Trust
	Nabeel Alsindi (NA)	GP & Clinical Lead for Primary Care and Long Term Conditions NHS Doncaster Clinical Commissioning Group (ad-hoc services provided by Yorkshire & Humber Clinical Senate)
	Susan Edge (SE)	Patient representative Academic Health Science Network (AHSN) PPI Senate

Ref	Item
1	**Welcome, Attendance and Apologies** EO welcomed everyone to the teleconference meeting and introductions were made. Apologies were noted. IM informed the panel members that he was now unable to participate in the Corby Review due to having to attend Coroner's Court, but would try and source a representative from EMAS.

	EO apologised for the delay in sending the information through to panel members as the clinical senate were waiting for a re-submission from the commissioning organisation. These were circulated on 19th October 2017. The supporting information provided by the sponsoring organisation is below: ➢ Presentation that summarises the options and the evidence paper (helpful read and doesn't take too long) ➢ Final MASTER evidence pack (The Evidence for Change). (This is quite a lengthy doc. Having discussed with the sponsoring organisation, we've agreed that the Executive Summary, Context for Change and The Options for change are the bits to definitely read. The Evidence for the Model (Statements 1 through to 12) can be referred to, if required. ➢ The panel members were particularly advised to look at 'statement 13': ***Please note: statement 13 further clarifies what the sponsoring organisation would like Clinical Senate members to review, consider and recommend.***
2	**Terms of Reference/ Questions** NH went through the list of questions in the TofR and considered whether the Clinical Senate had sufficient information and the following gaps were subsequently identified:- The TofR have slightly been amended: We are still doing our absolute best to increase primary healthcare professional input into the panel. 1. **Will these proposals deliver real benefits to patients (access/clinical outcomes/quality)?** It was suggested that they need to be a bit more explicit about real benefits. EO to amend the terms of reference, as these are standard questions. 2. **Is there evidence that the proposals will improve the quality, safety and sustainability of care?** Copy of mitigation analysis, particularly re A&E attendance 3. **Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?** Corby to share national policy guidance around same day access to primary care/a GP by March 2018 4. **Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?** Corby to supply a copy of the local authority Joint Strategic Needs Assessment 5. **Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?**

	Corby to supply information around demographics, particularly diversity **6. Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?** Access and transport – where are patients coming from who are accessing services? **7. Will the proposals help to reduce health inequalities?** Copy of quality impact assessment **8. Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?** Specifically re statement 13. Just to clarify - the Clinical Senate has been asked to confirm that the status quo for the current service is unsustainable and asked to consider all options and review recommendations in light of clinical safety, interoperability and sustainability. The Senate will only consider, review and make recommendations around clinical sustainability if this is included in the case for change (i.e. workforce/access – which we don't think has been supplied?) It is not within the Senate's remit to advise around financial sustainability.
	Summary EO is expecting to receive the documents by Wednesday 25th October.