West Midlands Clinical Senate

The Future of Acute Hospital Services in Worcestershire - **Stage 2 Clinical Assurance Review Panel Final Report**
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Foreword by: Panel Chair, Dr Helen Carter, Public Health Consultant, Public Health England; and Richard Corder, Patient Representative

This Stage 2 Clinical Assurance Panel Review was undertaken on behalf of the West Midlands Clinical Senate at the request of the NHS England Arden, Herefordshire and Worcestershire Area Team. This Review forms part of NHS England’s formal assurance process in respect of major service change.

The Worcestershire health economy faces a number of challenges, and the case for change setting out the need to reconfigure health services has been established elsewhere. The role of this Clinical Senate Review Panel was to review the current proposed service model prior to this going to wider public consultation, in order to provide assurance from the perspectives of: patient safety; clinical quality; and overall service sustainability.

The Panel brought together by the Senate, encompassed (where possible) many clinicians from different parts of the country. Due to the mobile nature of the clinical workforce, it was not always possible to locate clinicians with no history of working in the West Midlands. To complement the clinicians on the Panel, the patient voice and social care representatives were also included from outside the county. This methodology of sourcing Panel members from outside the county was a deliberate decision in order to ensure that an external, objective view would be obtained regarding the proposed service model. Having accepted that Panel members would not have a working knowledge of the county, the first Panel day was designed to bring everyone to a common level of understanding of the issues and challenges faced within the Worcestershire health economy.

The planned three-day review was extended to a fourth day in an attempt to reach a resolution for the conflicting views represented to the Panel. The Francis report challenges staff working within the NHS to speak with courage and candour. The Panel, therefore, acknowledges this quality demonstrated by the staff working at Worcestershire Acute Hospitals NHS Trust.

All of the Panel members and staff involved with this process accepted the clinical need for change. The Panel, however, was unable to support the proposed future model for Emergency Department provision at the Alexandra Hospital site due to concerns in respect of risks to patient safety.

This foreword has consciously been co-authored by the Chair of the Panel with the patient voice representative in order to demonstrate the driving force behind the decision reached by the panel: patient safety above all should be the overriding determining factor for proposed models of care. We would like, however, to thank all of the Panel members, as well as the Future of Acute Hospital Services in Worcestershire Programme Board and Programme management office, Worcestershire CCG colleagues and all of the staff from the Worcestershire Acute Hospitals NHS Trust for their contributions to this review.
1 Senate Chair Summary and Recommendations – Dr David Hegarty

The West Midlands Clinical Senate was asked by NHS England Arden, Herefordshire and Worcestershire Area Team to provide clinical assurance of the Future of Acute Hospital Services in Worcestershire Programme as part of NHS England’s Stage 2 assurance process.

The assurance sought was to assess the clinical quality, safety and sustainability of the Summary Model of Care developed as part of the Future of Acute Hospital Services Worcestershire Programme. The methodology utilised by the Clinical Senate Review Panel is described within the document and a Panel of appropriate clinical and non-clinical experts was convened.

The Clinical Senate Review Panel has concluded that the current position, robust evidence-based case for change, and the proposed service model, are clearly defined in the review. The Clinical Senate Review Panel has also concluded that there is an unsustainable model of acute health services across Worcestershire, which warrants a need for fundamental change and improvement. The Future of Acute Hospital Services in Worcestershire, therefore, provides the opportunity to improve the quality of care provided to the Worcestershire population.

The Panel came to a conclusion that the proposals set out within the Summary Model of Care to reconfigure the Obstetrics and Gynaecology and Emergency Surgery services were supported, but that clear plans needed to be drawn up to demonstrate how additional paediatric capacity could be developed at Worcestershire Royal Hospital. The Panel was unable, however, to support the detail of the proposed model of Emergency Medicine at the Alexandra Hospital as set out within the Summary Model of Care. Furthermore, further work is required to develop a common understanding between both staff and members of the public regarding when and where sick children from Redditch and Bromsgrove should be taken to. Importantly, the Panel felt very strongly that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across Worcestershire Acute Hospitals NHS Trust (WAHT) for this model from the perspectives of both patient safety and clinical sustainability.

It should be recognised that the Panel met and produced the report at a particular point in time. Subsequent to that, however, there have been significant workforce changes at Worcestershire Acute Hospitals NHS Trust, notably the resignation of a number of ED Consultants. It is clear though that these subsequent events reflect some of the conclusions drawn by the Panel as set out within the report and bear out its recommendations.

I would like to thank the Panel members for their expertise and insight in undertaking the review process and also contributing to the final report. I would like to thank the statutory agencies, 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 stage 2 assurance process.

The Future of Acute Hospital Services in Worcestershire – West Midlands Clinical Senate Stage 2 Clinical Assurance Report – Version 4.0 (Status: Final)
1.1 Summary

The West Midlands Clinical Senate was asked by the NHS England Arden, Herefordshire and Worcestershire Area Team 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.

The West Midlands Clinical Senate established a Panel of external clinical experts to review the proposed clinical model, and four Panel Review Days were held between November 2014 and January 2015. Documentary 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.

The Panel was also asked to make recommendations to the West Midlands Clinical Senate on whether to support the model. The recommendations are to be shared with the FoAHSW Programme Board and subsequently to the sponsoring organisations. These recommendations are summarised below.

1.2 Recommendations

Recommendation 1:
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:
The Panel 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 ongoing care.

Recommendation 3:
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.

Recommendation 4:
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:

- Making absolutely explicit the extent and remit of urgent/emergency paediatric cover
- Having a clear plan for dealing with paediatric emergency presentations at AH
• 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:
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.

2 Background

2.1 Geographical Background
There are three clinical commissioning groups within Worcestershire, reflecting the natural, geographic communities across Wyre Forest, Redditch & 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 Treatment Centre (KTC). 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 The Acute Services Review Process
In 2002, the then Worcestershire Health Authority implemented a plan called ‘Investing in Excellence’, which aimed to reconfigure acute services in Worcestershire and concentrate ‘hot’ services on WRH.

Worcestershire Primary Care Trust (PCT) was created in 2006. The Emergency Department Consultants and the Acute Trust determined that existing services were unsustainable and recommended that an acute service reconfiguration be taken forward. In 2012 a Joint Service Review (JSR) was established by the PCT and WAHT, supported by the Worcestershire Health and Care Trust and Worcestershire County Council. Thirteen service models were developed, covering options for hot and cold work across all three sites.

In April 2013, following the changes heralded by the Health and Social Care Act, the PCT ceased to exist. With the impending close down of PCTs in April 2013, the JSR was concluded with two principle options being identified. Responsibility for commissioning non-specialised acute hospital services within the county was handed over to the new Worcestershire clinical commissioning groups (CCGs). At the
culmination of the JSR process, two principal options had been produced for the future configuration of acute hospital services in Worcestershire.

During late 2013 (September), the CCGs established the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme to take forward the reconfiguration plans. In November 2013 an Independent Clinical Review Panel (ICRP) was convened in order to ‘assess the clinical quality, safety and sustainability of the outputs of work undertaken to develop Option 1 and/or Option 2, and to confirm the clinical quality, safety and sustainability of the clinical model(s) prior to public consultation’.

The ICRP recommended that a modified version of ‘Option 1’ should be worked up in more detail (Final Report of the Independent Clinical Review Panel, January 2014). Work has subsequently been progressed by the Task Groups working to the Clinical Sub-Committee of the FoAHSW Programme Board within Worcestershire in developing a Summary Model of Care, based on Option 1, and it is this service model that has been the subject of the West Midlands Clinical Senate Panel Review from November 2014 to January 2015.

Worcestershire clinicians have developed the Case for Change, with involvement from providers, commissioners (initially NHS Worcestershire and, subsequently, the three Worcestershire CCGs), representatives of patient groups and the public. This has built upon the original Case for Change set out in the Joint Services Review (JSR), taking into account the subsequent recommendations of the Independent Clinical Review Panel. Further details of the Case for Change are provided at Section 5 below.

**2.3 The Option One Model**

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The overarching model of care developed through the JSR was as follows:

- Consolidate Inpatient Paediatric services onto the WRH site in order to deliver and sustain clinically safe services, with local access for paediatric assessment at AH and WRH sites
- Consolidate Consultant Obstetric services onto the WRH site aligned with Paediatrics in order to deliver and sustain clinically safe services, with Midwifery-Led Units at both AH and WRH sites
- Establish a major Accident and Emergency Department at the WRH site with the capacity and capability 24/7 to receive major emergencies for the county and operate as a Trauma Unit; and
- Establish a networked local Emergency Unit at the AH site with the capacity and capability to receive and manage medically urgent cases and ambulatory emergency cases 24/7.

Under Option 1, Worcestershire Acute Hospitals NHS Trust would continue to run all three sites. Under Option 2, services currently run by Worcestershire Acute Hospitals NHS Trust at the Alexandra Hospital would be run by an alternative provider or providers.

The Independent Clinical Review Panel made the following recommendations in support of a modified Option 1:

- A modified version of Option 1 is supported (see recommendation 3). This version of Option 1 describes a service that will provide high quality, safe and sustainable care for the population of Worcestershire. The Panel recommends that this version of Option 1 is taken forward to Public Consultation

- Option 2 is not supported. Option 2 will result in a significant inequality in the provision of safe and sustainable services to the population of Worcestershire. The Panel recommends that Option 2 is not taken forward to Public Consultation

- Worcestershire Acute Hospitals Trust, working with its commissioners and provider partners, (should) establish a networked ‘Emergency Centre’ at the Alexandra Hospital (Recommendation 3, ICRP report 2014)

- Redditch & Bromsgrove CCG should consider commissioning a stand-alone Midwifery-Led Unit in North Worcestershire (Recommendation 4, ICRP report 2014)

- Worcestershire CCGs and WAHT should urgently review the safety and sustainability of emergency general surgery at the AH (Recommendation 5, ICRP report 2014)
• Worcestershire CCGs, working with Worcestershire County Council, should review the provision of public transport between North Worcestershire and the Worcestershire Royal Hospital in order to support access to high-quality, sustainable and safe healthcare for the population of Worcestershire (Recommendation 6, ICRP report 2014).

2.4 Scope and Limitations of Review

The scope of this Review is to provide Stage 2 clinical assurance of the Future of Acute Hospital Services in Worcestershire (FoAHSP) Programme and to assess the clinical quality, safety and sustainability of the Summary Model of Care, developed by the Task Groups working to the Clinical Sub-Committee of the FoAHSP Programme Board, prior to public consultation. This included reviewing the report and recommendations of the ICRP regarding the original (V1) Summary Model of Care.

Assurance was sought from the West Midlands Clinical Senate on the following:

a) review and assess the clinical case for change and the proposed model of care as developed by the Clinical Sub-Committee, supported by the three clinical task groups, and received by the FoAHSP Programme Board and sponsoring organisations, against the agreed criteria of:
   i. providing high-quality, safe and sustainable care for the population of Worcestershire, both now and in the future
   ii. enabling safe and sustainable organisations with sufficient numbers of patients to maintain skills and expertise
   iii. a model of care that is deliverable within workforce constraints
   iv. a configuration of services that will improve training, opportunities for research, recruitment and retention of staff and development of specialised services
   v. a good balance between access to local services, the promotion of choice and improving the quality of those services

b) consider the final clinical model(s) prior to public consultation against the above criteria and make recommendations on whether to support the model(s) to the West Midlands Clinical Senate and thereafter to sponsoring organisations and the FoAHSP Programme Board

c) consider and review the comments and recommendations made in the final report of the Independent Clinical Review Panel (January 2014) and other relevant external assurance reviews, including the views of Health Education West Midlands.

2.5 Limitations:

No specific limitations relating to the review were identified beyond its original terms of reference (see below).
3 Methodology of the Review

The methodology of the review was informed by national guidance (Clinical Senate Review Process: Guidance Notes 2014).

3.1 Terms of Reference

The aim of the Stage 2 Independent Clinical Review Team is to assess the clinical quality, safety and sustainability of the Summary Model of Care, developed by the Task Groups working to the Clinical Sub-Committee of the FoAHSW Programme Board.

The Panel is required to assess the clinical quality, safety and sustainability of the clinical model(s) prior to public consultation, including reviewing the comments and recommendations of the Independent Clinical Review Panel (ICRP) and other comments on the original (V1) Summary Model of Care. The Terms of Reference for the review were developed as per NHS England guidance (see Appendix 1).

3.2 Process

The West Midlands Clinical Senate collated advice between November 2014 and January 2015, assisted by an Independent Clinical Review Team (hereafter 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 (see Table 1 and Appendix 2). 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 3.

Panel review dates were held on 17th & 21st November and 11th December 2014 and an additional Panel review date was agreed for 19th January 2015 (see Appendix 4-7). The Panel reviewed documentation provided by the FoAHSW Programme Board, and heard presentations from individual members of the FoAHSW Programme Board. During Day 2 of the Review, on 21st November 2014, Panel members undertook site visits to WRH and AH, touring relevant clinical areas and culminating in a joint plenary session with the WAHT Medical Director.

Following Day 3 of the review, an additional day was sought by the Panel and scheduled in agreement with the Programme Board. All panel members were invited to attend and all remained updated electronically in order to incorporate their views for the additional day. Whilst only a small number of panel members attended Day 4, in agreement with the Programme Board, the day progressed as there was lay representation and clinical expertise.

This report presents the key issues that were discussed and emergent themes from the evidence presented (both documentary and verbally). It is not intended to be a
comprehensive record of the discussion. The Panel’s main observations and conclusions are presented as per Clinical Senate Review Process: Guidance Notes (June 2014).

Table 1 Independent Clinical Review Team

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<tr>
<td>Dr Helen Carter</td>
<td>Consultant in Public Health</td>
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Members:

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<td>Penny Brett</td>
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<td>John Radcliffe Oxford</td>
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4 Description of Current Service Model
(FoAHSW 2014 Pre Consultation Business Case)

WAHT currently provides services from three main hospital sites:
- Alexandra Hospital (AH) in Redditch;
- Kidderminster Treatment Centre (KTC) in Kidderminster; and
- Worcestershire Royal Hospital (WRH).

WRH and AH provide 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.

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.

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.

In light of its 2012/13 performance, national planning requirements and local commissioning intentions, WAHT recognised the need to 'develop and sustain (its) 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; and
- Establish a clinical configuration of services that supports other key strategic initiatives of the trust.

The following map at Figure 1 sets out the provision of NHS acute services in Worcestershire.
5 The Case for Change

It was necessary for the Panel to understand 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 Hospital Trusts (WAHT). It builds 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 has been 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 following information regarding the case for change is taken from the FoASHW Pre-Consultation Business Case Volume1 v7.9 (2014)

The Worcestershire health economy has been facing the same challenges as many health economies across the country and it has been recognised that there’s a need to make some changes in the way that services are delivered to ensure that services are safe and sustainable in the future.

More people are living longer with more long term conditions, which is placing greater demand on the acute sector. There’s also a shortage of clinicians, particularly in certain specialities, which is making it increasingly difficult to provide the right level of cover 24 hours a day, seven days a week on different hospital sites. National clinical guidance is also showing that patient care and outcomes can be improved if certain services are delivered in specialist centres, with specialist staff and facilities in one location.

For certain clinical specialities in Worcestershire, there are also some specific reasons why things need to change.

5.1 The Case for Change – Elective Care; Acute and Elective General Surgery and Orthopaedics

- National Hospital Standardised Mortality Ratios (HSMR) indicate higher than acceptable mortality rates at the AH. The rates were also higher when compared with services delivered at WRH site which were slightly lower than would be expected.

- The demographics of the Consultant body at the AH with a number of Consultants due to retire in the next few years.

- A national reduction in the number of junior doctors in surgery in training nationally. This reduction will make it increasingly difficult, if not impossible, for WAHT to continue to support two separate services and provide appropriate training.

- An increase in sub-specialisation leading to a reduction in those able to contribute to an emergency surgery rota.

- The loss of surgical specialist trainees at the AH several years ago due to limited training opportunities.

- Uncertainty of the future of Emergency at the AH has recently led to a loss of middle grade surgeons, which threatens the sustainability of a 24/7 resident rota.
- WAHT intends to further develop the Level 2 Trauma Unit at the WRH site, with management of semi-elective trauma (e.g. wrist fractures, hand injuries and fracture clinics) at the AH and the KTC. National hip fracture data identifies the requirement to improve outcomes. Inpatient trauma to be centralised at WRH where all of the other essential acute surgical services are based.

- WAHT wishes to invest in the creation of ‘Centres of Excellence’ for all elective Orthopaedics, Urology (including Urological Cancer) and a specialist Benign Upper GI Surgery service at the AH, with the creation of further ‘Centres of Excellence’ for all elective Colorectal Surgery, Reconstructive Breast Surgery, Vascular Surgery and Head and Neck Surgery at the WRH site. The proposed reconfiguration will not only concentrate expertise and facilities in single centres for the county but also reduce the conflict for resource that exists currently where acute and more routine surgical services are not separated. This will also improve the structure of training in surgery at all levels across the county, which is supported by the Workforce Deanery.

- There is a need to meet seven-day working standards (NHS England, December 2013) for surgical services – this standard is currently not met.

5.2 The Case for Change – Emergency Care

- The A&E departments at the AH and the WRH fall short of the recommended Consultant workforce, recommended by the College of Emergency Medicine (CEM).

- The provision of a Type 1 A&E department is dependent on 24-hour availability of: general surgery, laboratory (and diagnostic) services, inpatient paediatrics, acute medicine, radiology, trauma services and critical care.

- The proposed move of Inpatient Paediatrics, Obstetrics and emergency surgery will have a significant impact on the sustainability of a Type 1 A&E at the AH.

- The A&E Department at WRH will evolve into a Major Emergency Centre (as described in Professor Sir Bruce Keogh’s report, NHS England 2014) staffed with 14 to 16 A&E Consultants, some of whom will provide cover to the AH Emergency Centre on a rotating basis, supported by middle grade staff.

5.3 The Case for Change – Women and Children

5.3.1 Paediatrics
• There is a higher than expected admission rate for acute illness, and a longer length of stay for children, at the AH site compared with the WRH, despite a higher complexity of caseload at WRH.

• A NHS West Midlands Workforce Deanery report in 2010 highlighted a concern with staffing shortages at middle grade.

• The current service at WAHT meets only seven of the 10 standards in the Royal College of Paediatrics and Child Health (RCPCH) ‘Facing the Future’ document (Facing the Future, Royal College of Paediatrics and Child Health, 2013).

• There are only 5.8 whole time equivalent Consultants in post compared with the Royal College’s recommendation of 10 on the on-call rota.

• The county does not have a large enough population to support two Inpatient Paediatric departments.

• Children have better outcomes if they are treated in larger units with a higher concentration of specialist staff.

• It costs more to run two separate Inpatient Paediatric departments; this is not sustainable in the longer term.

• Children are admitted to the paediatric ward at the hospital overnight. The service admits an average of 5 or 6 children with medical problems to the AH every 24 hours. The majority of these go home within 24 hours, and the average length of stay is 1 day. With so few very sick children being admitted it is difficult for the doctors and nurses to keep their specialist skills up to date.

• Even those that are admitted currently could largely be managed through a paediatric assessment unit if available and fully operational.

5.3.2 Obstetrics

• Most women do not need a Consultant to supervise their labour and the birth of their baby. At the time of the review, approximately 2,100 babies are born every year at the AH, (this figure has reduced to 1900, as indicated by the Programme Board in May 2015), making it one of the smallest Consultant-delivered units in the country. Leading national advisors say this relatively small number of births means the AH will not be able to provide the recommended level of Consultant cover to provide safe maternity services in the long term.

• Too few babies born in the AH for a Consultant-led unit to be viable.

• There is a trend towards a higher number of preventable Serious Incidents at the AH compared with the WRH, despite a higher complexity of cases at the WRH site.
• There is no provision at AH for a paediatric intensive care unit.

• In line with a national shortage, WAHT has been unable to recruit middle grade doctors to cover the AH and WRH sites and is unable to meet the recommended level of Consultant cover (40 hours) at the AH and the level of cover (98 hours) at WRH.

• The NHS West Midlands Workforce Deanery expressed concern about the lack of training experience at the AH site. This may lead to the withdrawal of middle grade trainees.

• A report carried out by the Royal College of Paediatrics and Child Health (RCPCH Final Report WAHT November 2013) on Obstetric and Paediatric/Neonatal services found the current configuration to be unsustainable. The report noted that services do not meet current medical staffing standards and, unless changes are made, are unlikely to be able to recruit sufficient trained staff to do so in future.

• There is a clear co-dependency between Obstetrics and Paediatric services that suggests co-location of both services would be desirable in any case for reconfiguration.

The Panel was of the view that a clear and compelling case for change was 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.

6 Assessing Clinical Assurance for the Development, Delivery and Sustainability of the Clinical Model

The Commissioners provided and presented documentary and verbal information to the panel. Documentary evidence included: outline business case; case for change; model of care/final agreed clinical model, capacity model including ambulance transfer modelling; risk register; clinical vision; 1st stage ICRP final report and appendices; issues raised by the 1st stage ICRP regarding the summary models of care. From this information the Panel formed the following observations and views.

7 Day 1 Summary of Day 1 Panel Discussions by Theme and Topic (See Agenda Appendix 4)

The Panel was impressed with the honesty with which the commissioners presented the background and history of this process, and acknowledged the huge amount of planning and work that has gone into the acute services reconfiguration programme within Worcestershire. The Panel accepted the clinical case for change and that this acute services reconfiguration was a complex process to drive forward, both in terms
of having three separate clinical commissioning groups within the county, but also with a Trust providing acute hospital services to the local population across split sites.

A number of cross-cutting themes were discussed during the Day 1 Panel Review, and which the Panel felt would also be important to explore further on the Day 2 site visits in order to gain assurances that the proposed clinical model was of high quality, safe and sustainable for the future. These were:

- Organisational culture and values
- Public behaviour
- Workforce: staff resilience, capacity and training
- Speciality interdependencies
- Transfers between sites
- Planning numbers and modelling.

**Summary of day 1 (17 November 2014) – overview of issues and challenges**

- Workforce planning
- Capacity at WRH
- Staffing of theatres out-of-hours at AH
- Training at AH
- Plans for managing acute renal failure
- Delayed transfers of care
- ED staffing at AH
- Implementation of networked emergency model
- Impact on ambulance service and primary care
- Care of critically ill child out-of-hours at AH
- Public education and message about emergency paediatrics
- Awareness of ambulance staff outside the county
- Sustainability of consultant-led obstetric service at AH
- Enhanced community services
- Additional theatre and midwifery-led unit at WRH
- Anaesthetist capacity
- Patient choice and impact on neighbouring health economies
- Transport
7.1 Organisational Culture and Values

The proposed service model was felt to represent some significant changes in the ways of working for many staff within the Trust. This will, therefore, require thorough engagement across all levels of staff within the organisation in order to deliver what is proposed, not only with the Consultant workforce. The Trust’s approach to change management regarding the implementation of the model will, therefore, be critical to its successful implementation and sustainability.

7.2 Public Behaviour

There were concerns voiced by the Panel regarding assumptions made about public behaviour and, in particular, with respect to the intention to have paediatric cover at the AH only during certain hours of the day via a paediatric day assessment unit. This was felt to have the potential to be confusing for the public.

The following scenarios were considered:

i) Parental choice - in a situation where a child requires emergency care but there is potential for misunderstanding the services available, leading to parents bringing children to the AH site out of hours when there is no specialist paediatric cover; and

ii) Patient choice - leading to patients choosing to access hospital care in other health economies. Reassurances regarding potential impacts upon other neighbouring areas were sought by the Panel - specifically relating to existing services in South Birmingham and Warwickshire. Patient choice may also impact upon maternity services - specifically for more vulnerable women who tend to book at a later stage of their pregnancy and this may limit their opportunity to exercise patient choice.

7.3 Workforce: Staff Resilience, Activity and Training.

The Panel expressed concerns regarding the ability to maintain a resilient, safe and sustainable workforce within the Emergency Medicine department at the AH site. The Royal College of Emergency Medicine recommends that:

“All EDs should have an establishment of at least 10 EM Consultants to provide up to 16 hours a day of Consultant cover. Typically this will be 8am to midnight or 7am to 11pm. Ten Consultants can provide 16/7 cover only in departments with one Consultant scheduled to be on site out of hours at any given time.” (Emergency Medicine Operational Handbook: The Way Ahead, 2011).

It was accepted by the panel that the proposed model was not to have two full ED departments on both sites equating to 20 full-time equivalent Consultants. It was, however, recognised that there is a national shortage of emergency medicine Consultant and middle staff grades (Royal College of Emergency Medicine STEP
campaign 2014). This concern regarding the availability of ED staff, however, did not relate only to the Consultant workforce, but also all other grades of ED staff.

Members of the FoAH Sw Programme Board stated that staff would rotate between the AH and WRH sites. Further assurances were required by the Panel, however, in respect of the level of workforce planning that had been undertaken to underpin this approach - including plans for recruitment and retention of staff, and the acceptability of rotations between sites amongst lower-banded staff.

7.4 Speciality Interdependencies

Further assurances were sought regarding how the proposed model for the Emergency Medicine department at the AH site would be supported by other specialities, specifically Anaesthetics and Critical Care. The Panel was concerned to understand what this model would look like in practice, including out-of-hours care; taking into account the Royal College of Anaesthetists’ requirements for immediate airway support being available in a Critical Care Unit (Royal College of Anaesthetists 2012).

7.5 Transfers between Sites

There were two main areas of discussion regarding the need to move patients between sites:

i) Firstly, the Panel was keen to understand the impact on the West Midlands Ambulance Service (WMAS) of conveying Redditch and Bromsgrove patients to the WRH site, rather than to the AH site; as well as the non-urgent transfer of patients presenting to the incorrect site;

ii) Secondly, how the movement of both staff and visitors would be facilitated between sites, specifically those with limited incomes.

7.6 Planning Numbers and Modelling

The Panel wanted to have further, specific details and clarity regarding the practicalities of delivering the proposed model – specifically in relation to the proposed ED model at the AH site. It was accepted by the Panel that this would become clearer during the site visit on Day 2 and from talking with the frontline clinicians. Further assurances were also required, however, regarding capacity on the WRH site, including: the impact of an increasing number of A&E attendances on the ED at WRH (when the Trust is already struggling to manage bed capacity), the availability of theatre capacity for Caesarean section deliveries, and how the additional paediatric admissions could be accommodated on the existing paediatric ward.

The following section of the report outlines the key issues within the above six themes that were discussed by the Panel on Day 1, for the following service areas:
as well as looking at issues related to patient accessibility and public transport.

8 Day 1 Panel Discussion of Service Areas

Commissioners provided and presented a variety of information to the Panel as stated in section 7 above. From this information, the panel formed the following concerns and issues:

8.1 Acute and Elective General Surgery and Orthopaedics

8.1.1 Workforce

- The sufficiency of workforce planning undertaken (both for Consultants and other staff grades) to support the planned level of cross-site working
- The workforce capacity at WRH to absorb additional emergency surgical activity from Redditch and Bromsgrove; accepting that Consultant surgical cover had been built into the model at AH to support middle grade surgical assessment and then an advice line would allow GPs to direct Paramedics from the West Midlands Ambulance Service accordingly, in order to try to reduce transfers. It was also noted that work was continuing to establish an ambulatory General Surgery for the county which will be based at AH
- The capacity to staff theatres out of hours at the AH site, and a related concern that any such staff may be under-utilised; while accepting that, with the separation of acute and elective staff within the proposed clinical model, the need for out-of-hours intervention at AH would be much lower
- The challenge of retaining training grades at the AH site

8.1.2 Capacity and Patient Flow

- The need for clarity concerning plans for managing acute renal failure and dialysis within the clinical model, particularly as the Trust and commissioners are looking to repatriate dialysis services to Worcestershire
- The fact that delayed transfers of care continue to prove a challenge to the Trust, even with the county-wide ‘hub’ at WRH co-ordinating capacity, and a comparatively high level of community hospital provision within the county providing both additional beds and diagnostic capacity

8.2 Emergency Care
8.2.1 Activity and Patient Flow

- Concerns about the capacity to absorb additional emergency activity from Redditch and Bromsgrove at WRH, particularly in view of the current problems in managing bed capacity.

- Based upon their clinical experience the Panel had posed a number of possible clinical scenarios where 'once in a blue moon' events took place at the AH, to which it was not clear how robustly the proposed model and, specifically, the staffing structures would be able to respond in a timely and clinically safe manner. As an example, the Panel raised a scenario of a cardiac arrest patient admitted into ED at the AH site at 11pm. While it was pointed out that the patient could be attended by middle grades in medicine, ED and ICU, backed up by non-resident Consultants, the Panel raised concerns as to whether the required staffing numbers could be achieved to deliver this in practice

- The reliance on a modelling assumption that 96 per cent of emergency activity currently performed at AH will remain within the county, with only small outflows anticipated to University Hospitals Birmingham NHS Foundation Trust and South Warwickshire NHS Foundation Trust

- The Panel was supportive, however, of the intention to extend the recent pilot of a GP Urgent Care Centre into 2015, and felt that this could be a very promising and innovative model worthy of further evaluation

8.2.2 Workforce

- The level of ED staffing required at AH, both during core hours and out of hours (as noted in Section 8.1.3 above)

- The challenges faced in implementing the proposed model of networked emergency care across the two sites, including the expectation that Consultant and other staff groups would rotate between sites; notwithstanding the assurances provided to the Panel that physicians felt comfortable with the finalised arrangements and that significant efforts had been made to ensure the ED could attract a high calibre of staff

- Maintaining the standard of excellence in care at AH following the centralisation of inpatient Paediatrics to WRH and the retention of an adult-only ED department at AH; accepting that services such as diagnostics, endoscopy and CT (as well as general surgery, ED and ICU) would be rotated in order that practitioners would have an equal skill level across the county

- The impact on other services, such as ambulance services and primary care

8.2.3 Emergency Paediatrics
The Panel explored with members of the FoAHSW Programme Board and acute colleagues the scenario of a critically ill child being brought by their parent or carer directly to the AH site out of hours. Assurance was sought that junior members of staff would receive adequate clinical support to mitigate the level of risk to the critically ill child. The members of the Programme Board accepted that it was inevitable that some parents and carers would present with ill children out of hours at the ‘wrong’ hospital. The Panel, however, was assured that the Anaesthetic Department at AH had agreed to provide care while paediatric support was arranged - either from a Paediatrician travelling from WRH or the child being transferred by ambulance to the WRH site. While the panel can accept this mitigates the risk for the paediatric patient, it temporarily increases the risk for the critical care patients due to there being one resident anaesthetist at AH out of hours.

8.2.4 Patient and Public

- Concern that an incorrect message might be being sent that paediatric patients could attend A&E at the AH site 24 hours a day. The Panel suggested the AH ED might more appropriately be labelled as a ‘Paediatric Primary Care Service’ in order to distinguish it from an emergency service available for children. It was agreed that this clarity was important and that public information, advice and education would form an essential component in the further development of the model.

- A significant amount of public education would be required to be undertaken to ensure that the public knew where to go at what time of day and for what age group.

- While acknowledging the significant amount of work that had taken place with the West Midlands Ambulance Service (WMAS) to define guidelines regarding which patients should be taken where, the Panel, however, noted that ambulance crews from outside the immediate Worcestershire vicinity might not be aware of the local guidelines, which could present a risk to the proposed model for transferring patients between sites.

8.3 Paediatrics

8.3.1 Ambulance Transfer

- The need to ensure ambulance transfer protocols were in place to ensure that children were able to be cared for in the appropriate place.

8.3.2 Capacity

- It was confirmed that the estimated maximum number of patients that would need to be transferred from AH to WRH was three per week. It was envisaged that enhanced hospital-at-home and community support would reduce the number of transfers required.
8.4 Obstetrics

8.4.1 Workforce

- The panel commented on the ability to sustain a Consultant level of Obstetric service at AH and a safe, 24/7 Consultant-led paediatric rota, accepting that plans were in place to enhance the community Paediatric and Midwifery services workforce in Redditch and Bromsgrove

8.4.2 Activity

- It was noted that plans were in place for a second theatre at WRH as well as a Midwifery-Led Unit. Furthermore, levels of Consultant input were planned to reach 98 hours of labour ward cover. Plans were described to develop dual Anaesthetic rotas and the capacity for dual Caesareans should this be required. The panel recommended careful consideration of the capacity of anaesthetists to cover this additional duality. It was also confirmed that the Midwife-Led Unit currently being built could, in theory, accommodate up to 1,000 additional births

- The Panel was presented with the modelling activity (FoAHSW Activity Modelling to Support Assurance Process June 2014), that had been described by the working groups. The Panel specifically had concerns regarding the assumptions upon patient choice and the impacts that this may have upon neighbouring health economies

8.4.3 Public Transport

- The issue regarding patient, public and staff transport links between the AH and WRH as there is currently only a limited bus service available between the two sites. Further work would be required to ensure that patients, relatives, visitors and staff were not placed at a disadvantage as a result of poor transport linkages between the two sites

- While it was noted that a number of solutions to the issues of improving accessibility and public transport links between the sites were being considered, including more car parking at WRH, the implementation of a ‘Park and Ride’ scheme and funded transport links, research commissioned by the FoAHSW Programme Board to determine how service users travelled to the hospitals and whether their journeys were simple concluded that as many as 10 per cent of service users, including those with protected characteristics and those on low incomes, struggled to reach the hospitals in order to access health services.

- The Panel accepted public transport was being actively considered by the Programme Board and pre consultation engagement activity had taken place, appropriate for this stage in the development of the proposed models
9 Summary of Day 1

The key issues arising from Day 1 were summarised as follows:

1. The Panel sought more clarity as to the operational details and practicalities regarding the emergency facility at the AH and its cover arrangements. More robust information was required regarding attracting employees to the AH site, specifically the recruitment plans for the ED Consultant workforce.

2. The Panel was supportive of some form of ED provision at the AH site, however, there was some concern as to the capacity available for Trauma and Paediatrics at AH and reassurance would be required that this had been considered adequately by the FoAHSW Programme Board.

3. The Panel expressed general support for the proposed surgical model in Worcestershire, but wished to consider the practicalities of how this would be implemented on the Day 2 site visit.

4. Further clarity was also required regarding the capacity within the paediatric community nursing service and community hospitals that would enable children to be discharged more rapidly with home oxygen in order to distinguish between ambition and the panel’s collective clinical experiences. It was uncertain whether the proposed model had been future-proofed for demographic or financial sustainability, and concerns were also expressed about cross-border flows.

5. Concerns were raised by the Panel members about some of the assumptions used to model activity, such as the assumed reduction in Caesarean-section rate, and the reality of staff being prepared to travel between sites, noting that there may be greater financial impacts for staff on lower pay grades.

6. The Panel wished to explore further on the Day 2 site visit whether the Anaesthetic provision at WRH was sufficiently resilient to manage increasing emergency surgery requirements, and if the resident anaesthetist at the AH site had sufficient support out of hours. Clarity was also required regarding the need for High Dependency beds.

7. The Panel wished to explore further at the Day 2 site visit the delivery suite capacity, and expressed concern at the notion of flexing it for use with high-risk patients, wishing to explore this further with clinicians at the ‘coalface’.

8. Issues with Paediatric ED and Assessment Unit capacity also needed to be considered in more detail at the site visit, and especially the clinical management out of hours of severely ill paediatric patients. It was agreed by Panel members that there is a requirement for public education regarding the service available and that the consultation to date had been appropriate for this stage of development of the model. Not all Panel members, however, were convinced that the level of patient safety would be consistent across both sites, based upon the evidence that had been presented, and there was also a
concern that the number of patients seeking out-of-county treatment had been underestimated

9. The Panel also considered that since WMAS support to the proposed model would be an essential ingredient to its successful operation, it would be vital for the Panel to seek formal views from the West Midlands Ambulance Service.

10 Day 2

(See Agenda Appendix 5)

Day 2 provided an opportunity to visit the hospital sites of WAHT. Kidderminster hospital and treatment centre was not visited as this site was outside of the terms of reference for this review. The Chair and Chief Executive of WAHT met with clinical review panel at the start of the day. Panel members were then split into relevant groups of their speciality and interest:

A&E
Critical Care/Surgery
Paediatrics
Obstetrics & Neonates

Each group was accompanied by programme team leads and a Directorate Manager led the tour. The panel had the opportunity to meet lead consultants, nurses and doctors from the Trust who talked through the proposed model for their service; this was followed by a question and answer session.

10.1.1 Day 2 Summary of Discussions by Theme and Topic

<table>
<thead>
<tr>
<th>Summary of day 2 (24 November 2014) – site visits to AH and WRH</th>
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<td>- Recruitment and retention of staff</td>
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<td>- Impact on anaesthetics</td>
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<tr>
<td>- Need for detailed understanding of patient numbers and modelling</td>
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<td>- Patient safety of emergency care at AH</td>
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<tr>
<td>- Apparent lack of clinical support for proposed emergency model at AH</td>
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<tr>
<td>- GP-led urgent care centre at AH</td>
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<tr>
<td>- Staffing levels and national shortage of ED consultants</td>
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<td>- Patient understanding of ED provision at AH</td>
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The topics for discussion on Day 2 was informed by cross cutting themes identified in Day 1 and included further evolving issues: the impact of the new model on recruitment and retention of staff as well as on other interdependent clinical areas, such as Anaesthetics, and the need to develop a detailed understanding of patient numbers and modelling (e.g. by day of week and time of day). The main topic of discussion, however, was the patient safety of the proposed model of emergency.
care at the AH site, and the apparent lack of clinical support for this model in terms of risks to patient safety not being sufficiently mitigated.

The GP-led Urgent care Centre at AH had opened a few days previously and the Panel was encouraged by its layout and operating model. While further evaluation was being undertaken, this was judged to be a very promising model that appeared to represent good clinical practice.

From the site visit on Day 2, assurances were received by the Panel in terms of the proposed models for:
- Elective and Emergency Surgery; and
- Maternity and Inpatient Paediatrics - although further information was sought regarding bed numbers and modelling.

Some assurances were received regarding:
- Anaesthetics cover at the AH site - although there were still concerns raised regarding the provision of immediate airway support on critical care, as required by Royal College guidelines; and assumptions that the on-call Anaesthetist would provide back-up support to the ED. It was accepted by the Panel that an on-call Consultant could be called from home, although there may be a delay to this in an emergency scenario that could potentially result in a risk to patient safety.

There was considerable discussion, however, between the Panel, commissioners, frontline clinicians and the management from the Trust regarding the proposed model for the ED at the AH site and further assurances were required by the Panel in respect of the following concerns:

- Lack of frontline clinical staff support for the model in terms of risks to patient safety and clinical service sustainability. This was not limited to the consultant workforce, but included other staff groups. It was noted that only one out of the nine ED Consultants spoken to by the Panel had expressed support for the proposed model. While the Panel recognised that engagement had taken place with the Consultant workforce by the Trust regarding the development of the model, the fact that almost the entire ED Consultant body was currently not supportive of this, due to concerns about clinical risk and patient safety not being adequately mitigated, was a major concern
- Planned Consultant and middle grade staffing levels across both sites fell below the Standards for Intensive Care Units (2013) (as per Section 8.1.3, above)
- The impact of the current national shortage of ED Consultants and middle grades on the Trust’s recruitment plans
- Patient behaviour in terms of their understanding of the model of ED provision at the AH site; specifically in relation to where to take ill children out of hours and the potential for misunderstanding amongst the public in terms of what
services are and are not provided at the AH site based on the day of the week and time of day.

11 Day 3 Summary of Discussions by Theme and Topic
(See Agenda Appendix 6)

<table>
<thead>
<tr>
<th>Summary of day 3 (11 December 2014) – proposed ED model at AH</th>
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<td>• Staffing levels</td>
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<td>• Cross-cover between sites</td>
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<td>• Management of &quot;once in a blue moon&quot; events</td>
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<td>• Lack of frontline clinical support</td>
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Day 3 was focused solely on addressing the Panel's concerns regarding the proposed ED model of care at the AH site. By way of preparation for Day 3, the Panel had requested responses to specific questions from the FoAHSW Programme Board following the site visit on Day 2. The Programme Board responded and submitted the relevant documentation including (but not exhaustive) WAHT 2014/15 to 2018/19 Integrated Business Plan; Central Midlands Commissioning Support Unit (2014) paediatric, maternity and emergency care activity modelling to support assurance process; and the FoAHSW (2014) Stakeholder and Public Engagement Record.

In respect of a question concerning the specific proposals to staff the EDs at AH and WRH to a level at which the service was both safe and sustainable, the Panel was informed that the medical model post-reconfiguration, which had been developed by the Emergency Care Task and Finish Group, required an establishment of 16 Consultants working across a networked, county-wide service. In the interim, the Panel was informed that the Trust planned to expand the Consultant numbers at WRH during 2015/16 in order to attain at least the national average level of Consultant staffing as a first step towards meeting Royal College recommendations.

The Panel raised a related concern that robust plans should also be in place to ensure the proposed clinical model at AH would be viable for ED trainees (see footnote 1). The response received was that Health Education West Midlands has signalled that it may reduce middle grade training numbers at the AH although, if this came to pass, the Trust would seek to mitigate this through the appointment of non-training middle grades, fellows and locums, as necessary. It was also clarified that the Trust intended to recruit Advanced Nurse Practitioners to reduce the reliance on Consultants within the ED.
The Panel also requested clarification on the classification of the department at the AH site and, specifically, whether this would remain as an ED or become an Urgent Care Centre. The response received was that the model recommended by the ICRP and agreed by commissioners was that of networked ED, Urgent Care Centre and Minor Injuries Unit at AH. In addition to the Urgent Care Centre networking with the ED, the proposed county-wide, networked urgent care model would also extend to the community-based Minor Injuries Units.

With regard to how the ED Consultants will work between both sites, the Panel was informed that the Emergency Care Task and Finish Groups (which included 1 ED Consultant) had recently developed the county-wide, networked model to include either 16 or 20 Consultants, with both EDs at AH and WRH having agreed this model in principle. The Trust has also undertaken to work with both of the current Emergency Departments (Consultants and other healthcare professional groups) and commissioners during the programme implementation phase in order to engineer the workforce for the future within Worcestershire.

WMAS provided a very clear and helpful presentation that detailed the impact of the proposed service changes upon the ambulance service, including additional travel and turnaround times entailing additional cost. Although WMAS has an existing shortfall in trained paramedics and despite the time lag in training more crew members, the panel was assured that provided the extra funding required was made available, WMAS would be able to address this. The Panel also received assurances from the Worcestershire CCGs that a business case for this additional funding had been included within their commissioning intentions.

Despite the assurances given to the Panel regarding future ED staffing levels and WMAS being able to manage ambulance activity, the Panel remained concerned about the proposed ED model at the AH site, particularly in respect of:

i. workforce recruitment and retention
ii. public behaviour and choice, specifically out of hours
iii. staff skills remaining up-to-date through the practicalities of rotating staff between sites
iv. cross-cover between sites, specifically non-resident Consultant cover
v. the management of ‘once in blue moon’ events, e.g. Anaesthetics being called to support a paediatric cardiac arrest in the Emergency Department and a patient requiring urgent re-intubation within the Critical Care Unit
vi. inadequate staffing levels within the medium-to-longer term, set within the context of the national staffing shortages
vii. uncertainties regarding the formal view of Health Education England regarding the viability of providing trainees in ED at the AH site

Smith (2015) Health Education West Midlands (HEWM) has supplied evidence to the review process and will continue to work with all colleagues and organisations to deliver high quality education and training to maintain and improve the quality of patient care within a high quality education environment. There has been concern about the future of specialist registrars at the Alexandra Hospital site. If services are reconfigured on that site such that curriculum delivery within an appropriate healthcare environment is no longer possible then these registrars will need to be re-allocated along with other trainee doctors as appropriate. This will be done to minimise disruption to patient care. If the Worcester Hospital site is

The Future of Acute Hospital Services in Worcestershire – West Midlands Clinical Senate Stage 2 Clinical Assurance Report – Version 4.0 (Status: Final)
viii. lack of frontline clinical support for the model: no additional evidence had been presented to the Panel to indicate a change in the views of frontline clinicians regarding their concerns about patient safety with respect to the proposed clinical model.

Due to the inability to reach consensus between the Panel, members of the FoAHSW Programme Board and CCG led Task and Finish Groups, on the above issues, it was proposed that an additional, fourth Panel Day be held in January 2015 to allow additional engagement activity to be undertaken with frontline clinicians in order to explore further what mitigations could be put in place to manage the clinical risks arising from the proposed model. It was planned that a subsection of the Panel would then meet together with the frontline clinicians, Trust management and commissioners in an attempt to reach a consensus view on this issue.

12 Day 4 Summary of Discussions by Theme and Topic  
(See Agenda Appendix 7)

Summary of day 4 (19 January 2015) – review the proposed ED model at AH
- Recruitment and retention of additional ED consultants
- Viability of training
- Management of increased clinical risk
- Patient safety
- Public choice and behaviour – impact on outflows
- Clarity of understanding of model for emergency paediatrics
- Lack of support from frontline clinical staff
- Impact of patient safety triggers being breached

The Panel Stage 2 assurance review was originally envisaged as taking place over three days during November and December 2014 (see the indicative timescales within the terms of reference at Appendix 1). As described above, however, a fourth Panel Day was added, in agreement between the FoAHSW Programme Board, WAHT, the Worcestershire CCGs and the West Midlands Clinical Senate Review
Panel, as deemed necessary to complete a thorough and comprehensive review of all areas within the new clinical model.

The focus of Day 4 was again specifically to review the proposed Emergency Department clinical model at the AH site, due to the unresolved issues from Day 3 and lack of agreement on the model between the Panel, clinicians from the Trust, the senior management at the Trust and the Worcestershire CCGs. A smaller panel composition was present on Day 4, reflecting the focused nature of the discussions regarding the ED model.

All of the WAHT Emergency Department Consultants were invited to attend Day 4 and all but one of the Consultants were able to be present during the course of the day.

The key themes that emerged from the further discussions on Day 4 included:

- Workforce
- Clinical risk
- Public choice and behaviour
- Proposed paediatric model at the AH site
- Independent Clinical Review Panel’s report and clarity of recommendations
- Engagement within WAHT
- Other service interdependencies and impacts.

12.1 Workforce

The Panel remained concerned that were the new model to be implemented, staffing difficulties would be experienced across each of the following groups of staff, resulting in the potential detrimental impact on patient safety:

- ED Consultant workforce: concerns remained about the likelihood of being able to recruit and retain sufficient additional ED Consultant staff to enable the model to be safe and sustainable, when set within the context of a national shortage of ED Consultants. Concerns were also voiced regarding the desirability to staff of working at the AH site once key services had been removed

higher specialist training grades: there is currently a larger proportion of training grades located at the AH site than the WRH site (i.e. one at WRH compared with six at AH). The view from one of the Trust’s Postgraduate Clinical Tutors was that if the proposed draft acute Surgical services policy is implemented, this will result in the ED at the AH losing its Trauma status, and the trainees, therefore, would no longer be placed there from August 2015, resulting in a non-viable and non-sustainable service. Loss of training accreditation for the AH would not mean that the training posts would necessarily transfer instead to the Worcester site, but rather they would be placed elsewhere within the region. This would impact dramatically upon the
Emergency Department’s workload, leading to greater concerns regarding patient safety. This would also entail the service shifting from a Consultant-led service to a Consultant-delivered service. Health Education West Midlands (HEWM) supplied evidence to the Clinical Senate review process (see footnote1) stating on-going discussions with the FoAHSW Programme Board and reconfiguration and the impact on specialist registrars and other trainee doctors as appropriate.

- **Advance Nurse Practitioners (ANPs):** eight ANPs had commenced training with Worcester University, although they would not be trained for another year and then would only be able to perform their role in an ED within a narrow, protocol-driven remit. While their contribution was valued, the clinical consensus amongst the Panel, resulting from experience, was that ANPs could not act as substitutes for middle grade/higher specialist training grades.

### 12.2 Clinical Risk

- With the proposed model for the Emergency Medicine Department at the AH site and a substantial relocation of interdependent services (i.e. emergency surgery and Inpatient Paediatrics) both the Panel and the frontline clinicians took a common view that the ED Consultants working on this site would become responsible for managing increasing levels of clinical risk. While it was noted that a major part of the role of ED Consultants was in identifying, assessing and managing risk, nonetheless the changes represented by the proposed model were judged as increasing their exposure to risk, thereby resulting in a potential reduction in patient safety at the AH site.

### 12.3 Public Choice and Behaviour

- While the Panel acknowledged that modelling of travel times had been undertaken by the Programme Board, it felt that only limited work had been undertaken as yet regarding public behaviours and the impact this may have following the removal of Inpatient Paediatrics from AH. Further concerns were noted by the Panel with respect to the impact these changes may have upon patient flows to neighbouring health economies (e.g. South Birmingham and Warwickshire) and the apparent lack of analysis undertaken by the FoAHSW Programme Board to date in setting the proposed changes within a broader health economy context. The FoAHSW Pre Consultation Business Case (2014) alludes to letters of support from neighbouring Providers and the Programme Board referred to these in presentations but this evidence was not reviewed by the panel.

### 12.4 Proposed Paediatric Model at the AH Site
The Panel had read and heard many different variations and interpretations regarding the proposed model of delivery of Paediatric emergency care, both in and out of hours, at the AH site. This resulted in the Panel concluding that further work will be required with staff and the public to ensure that consistent messaging and interpretation of any future model is fully understood by both. If this further work does not happen, there remains a risk that ill children could end up in the wrong location, receiving inappropriate care and potentially resulting in serious incidents.

12.5 Role of the Independent Clinical Review Panel’s Report

- A teleconference was held between the Panel and the Chair of the previous Independent Clinical Review Panel (ICRP) in order to fully understand the recommendations contained within this earlier report (see Section 3.3 above). It was explained that the conclusions from the ICRP report articulated a vision that some ED provision was required on the AH site because it would not be possible for an additional 16,000 ambulance conveyances to flow to the WRH site due to capacity constraints. The Chair of the ICRP, however, expressed that the expectation was that further planning would take place by the FoAHSW Programme Board to determine the details of how this could be delivered.

- This dialogue with the Chair of the ICRP helped the Panel to understand the conclusions and recommendations of the ICRP report and the Panel concluded that it was not in disagreement with the ICRP. What the Panel felt they could not support, however, was the detail of the current proposed model that had been developed. It was with respect to the detail of the proposed model that the Panel had expressed its concerns regarding patient safety, rather than with the ICRP recommendation in favour of a proposed modified Option 1, which included an ED within a networked 'Emergency Centre' at the AH site.

12.6 Engagement within the Provider (WAHT)

- It was accepted by the Panel that a certain amount of clinical engagement had occurred within WAHT, and that a number of individuals within the Trust had devoted a considerable amount of commendable effort into trying to develop a proposed model that would meet the ICRP’s recommendations, working in partnership with the Worcestershire CCGs. This is evidenced by the submission by the FoAH SW Programme Board Stakeholder and Public Engagement Record – Pre Consultation (2014). This record demonstrates the audit trail of clinical engagement events and opportunities. Significantly, however, the Panel received three letters signed by a number of Consultants across a range of specialities that voiced concerns with regard to their level of
engagement and, hence, support within the planning process. These groups of clinicians had written formally to the Panel stating their view that they were unable to support the current proposed model because of patient safety concerns. All of these groups accepted that there was a pressing need for change and, therefore, for a new way of working to be developed but, equally, all felt strongly that they were not in a position to be able to support the proposed model as it currently stood. All accepted that there was no ‘perfect solution’, however, and, therefore, compromises would have to be reached between different clinical specialities working together with the aim of avoiding any adverse impacts on patient safety.

12.7 Other Service Interdependencies and Impacts

- The ED Consultants expressed concern that short and medium service changes might be undertaken without consultation due to patient safety triggers being breached. The panel received information regarding the Quality and Service Sustainability sub-committee from the FoAHSW Programme Board from early on in the review process. The sub-committee provides clinical leadership and ensures existing services are safe and sustainable. The risk register holds the current risks being overseen and mitigating actions being undertaken. There was agreement by the panel that it was highly undesirable for any changes to be made outside of this strategic plan and, therefore, every effort should be made to support all of the clinicians at WAHT to reach a solution that delivers the best outcomes in terms of patient safety, choice and sustainability and has the ownership of frontline staff.
13 Recommendations, Conclusions and Advice

Based upon the evidence presented to the panel, both written and verbal, the Panel has reached the following conclusions and recommendations regarding the Summary Model of Care for the FoAHSW Programme:

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 ongoing 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 ongoing 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

• 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.
14 References

FoAHSW Activity Modelling to Support Assurance Process, Modelling the effect of Changes to Maternity Service in Worcestershire draft v1.01 (June 2014)

FoAHSW Ambulance Transport Modelling (West Midlands Ambulance Service NHS Foundation Trust (November 2014)

FoAHSW Activity Modelling to Support Assurance Process, Modelling the effect of Changes to Emergency Care in Worcestershire draft v1.01 (June 2014)

FoAHSW Activity Modelling to Support Assurance Process, Modelling the effect of Changes to paediatric Services in Worcestershire draft v1.01 (June 2014)

FoAHSW Independent Clinical Review Panel Table Top Review of the Model of Care (N Beasley, July 2014)

FoAHSW Joint Service Review Case for Change (November 2014)

FoAHSW Pre Consultation Business Case Volume 1 v7.9 (November 2014)

FoAHSW Programme Board Appendix to the Pre-Consultation Business Stakeholder and Public Engagement Record Nov (2014).

FoAHSW Proposed Model of Care (November 2014)

FoAHSW Quality Impact Assessment (Emergency Care, Planned Care and Women and Children (November 2014)

FoAHSW Quality and Service Sustainability Sub-Committee TOR Nov (2014)

FoAHSW Quality and Service Sustainability Sub Committee Risk Register (October 2014)


FoAHSW 2 and 5 Year CCG Strategies – Clinical Vision (November 2014)


Royal College of Anaesthetists (2012) – Raising the Standard: a compendium of audit recipes; section 3.3 Airway Problems. p117
Royal College of Paediatrics and Child Health (2013) Back to Facing the Future: An audit of acute paediatric service standards in the UK.

Royal College of Paediatrics and Child Health; FINAL Report Worcestershire Acute Hospital Trust (November 2013)

Smith, Russell Russell.smith@wm.hee.nhs.uk; Health Education England Advice for Inclusion in the West Midlands Clinical Senate report (13.2.15)


The Faculty of Intensive Care Medicine / The Intensive Care Society (2013); Core Standards for Intensive Care Units, Edition 1.


15 Glossary of Terms

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

A&E – Accident & Emergency
AH – Alexandra Hospital
AMU – Acute Medical Unit
ANP – Advanced Nurse Practitioner
BWH – Birmingham Women’s Hospital NHS Foundation Trust
CAMHS – Child and Adolescent Mental Health Service
CapEx – Capital expenditure
CDU – Clinical Decisions Unit
CCG – Clinical Commissioning Group
CEM – College of Emergency Medicine
CHD – Coronary Heart Disease
COPD – Chronic Obstructive Pulmonary Disease
CQC – Care Quality Commission
CRG – Clinical Reference Group
DAU – Maternity Day Assessment Unit
DTOCS – Delayed Transfer of Care
EAC – Equivalent Annual Cost
ED – Emergency Department
EM – Emergency Medicine
ENT – Ear, Nose and Throat
FoAHSW – Future of Acute Hospital Services in Worcestershire
GP – General Practitioner
HEWM – Health Education West Midlands
HOSC – Health Overview and Scrutiny Committee
HWBB – Health & Well-Being Board
ICRP – Independent Clinical Review Panel
ICRT – Independent Clinical Review Team
ICU – Intensive Care Unit
IIA – Integrated Impact Assessment
JHWS – Joint Health & Well-Being Strategy
JSNA – Joint Strategic Needs Assessment
JSR – Joint Services Review
KHTC – Kidderminster Hospital and Treatment Centre
LoS – Length of Stay
MAU – Medical Assessment Unit
MFF – Market Forces Factor
MIU – Minor Injuries Unit
PCT – Primary Care Trust
WMAS – West Midlands Ambulance Service
WRH – Worcestershire Royal Hospital
16 Appendices
17 Appendix 1 Terms of Reference
West Midlands Clinical Senate

*Future of Acute Hospital Services in Worcestershire (FoAHSW) Review*

**Terms of Reference**

First published: October 2014

Prepared by
Victoria Millward, Quality Improvement Locality Manager
Angela Knight Jackson, Clinical Senate Manager
TERMS OF REFERENCE

Independent Clinical Review Panel
The Future of Acute Hospital Services in Worcestershire (FoAHSW) Review – 2nd Stage Assurance
Sponsoring Organisation: FoAHSW Programme Board
Clinical Senate: West Midlands

NHS England (regional or area team): Arden Herefordshire and Worcestershire Area Team, NHS England

Terms of reference agreed by:
Name on behalf of Clinical Senate
Name on behalf of sponsoring organisation
Date:

1. Clinical Review Team Members

Chair:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Dr Helen Carter</td>
<td>Consultant in Healthcare Public Health</td>
<td>West Midlands Public Health England</td>
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Members:

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<th>Name</th>
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<tr>
<td>Dr Rashid Sohail</td>
<td>Interim MD EMAS</td>
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<td>Dr Peter-Marc Fortune</td>
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<td>Prof Emergency Medicine</td>
<td>South Tees Hospitals NHS Foundation Trust</td>
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<td>Alistair Douglas</td>
<td>Consultant Physician and Nephrologist, Renal Services</td>
<td>NHS Tayside</td>
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<td>Mr Peter Sedman</td>
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<td>Mr Athur Harikrishnan</td>
<td>General and Colorectal Surgeon</td>
<td>Sheffield Teaching Hospital NHS FT</td>
</tr>
<tr>
<td>Edward Davis</td>
<td>Orthopaedic Surgeon</td>
<td>The Royal Orthopaedic Hospital</td>
</tr>
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<tr>
<td>Duncan Learmonth</td>
<td>Orthopaedic Surgeon</td>
<td>The Priory Hospital Birmingham</td>
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<tr>
<td>Penny Brett</td>
<td>Head of Midwifery</td>
<td>Peterborough City Hospital</td>
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<tr>
<td>Eleri Adams</td>
<td>Neonatologist</td>
<td>John Radcliffe Oxford</td>
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<tr>
<td>Beverly Ingram</td>
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<td>Andrea Pope-Smith</td>
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<td>Dr Jackie McLennan</td>
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<td>Mr Jeremy Groves</td>
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<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Mr Richard Corder</td>
<td>Patient and Public Representative</td>
<td>Independent Clinical Review Team Member (Lay Representative)</td>
</tr>
<tr>
<td>Angela Knight Jackson (in attendance)</td>
<td>Clinical Senate Manager</td>
<td>West Midlands SCN and Senate, NHS England</td>
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<tr>
<td>Victoria Millward (in attendance)</td>
<td>Quality Improvement Lead Manager</td>
<td>West Midlands SCN and Senate, NHS England</td>
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<tr>
<td>Karen Edwards (in attendance)</td>
<td>Senate PA</td>
<td>West Midlands SCN and Senate, NHS England</td>
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<tr>
<td>Alison Lake (in attendance)</td>
<td>Admin Support</td>
<td>West Midlands SCN and Senate, NHS England</td>
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**N.B.** The team will not include any individuals that will be, or have been, involved in any other part of the NHS England assurance process for this service change. 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 assess the clinical quality, safety and sustainability of the Summary Model of Care, developed by the Task Groups working to the Clinical Sub-Committee of the FoAHSW Programme Board, as amended.

To confirm the clinical quality, safety and sustainability of the clinical model(s) prior to public consultation, including reviewing the comments and recommendations of the 1st stage assurance ICRP and other comments on the original (V1) Summary Model of Care.

2.2 Objectives

The Independent Clinical Review Panel will:

a) review and assess the clinical case for change and the proposed model of care as developed by the Clinical Sub-Committee, supported by the three clinical task groups and received by the programme board and sponsoring organisations, against the agreed criteria of:

   i. providing high-quality, safe and sustainable care for the population of Worcestershire, both now and in the future
   ii. enabling safe and sustainable organisations with sufficient numbers of patients to maintain skills and expertise
   iii. a model of care that is deliverable within workforce constraints
   iv. a configuration of services that will improve training, opportunities for research, recruitment and retention of staff and development of specialised services
   v. a good balance between access to local services, the promotion of choice and improving the quality of those services

b) consider the final clinical model(s) prior to public consultation against the above criteria and make recommendations on whether to support the model(s) to the West Midlands Clinical Senate and, thereafter, to sponsoring organisations and the FoAHSW Programme Board

c) consider and review the comments and recommendations made in the final report of the 1st Independent Clinical Review Panel (January 2014) and other relevant external assurance reviews including the views of the Health Education West Midlands Deanery.
3. Timeline

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<tr>
<td>19.09.14</td>
<td>Contact panel members</td>
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<td>13.10.14</td>
<td>Agree terms of reference</td>
<td>CS, A,H&amp;W Programme Board</td>
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<td>Request for FoAHSW documentation from the sponsoring organisation</td>
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<td>COI, Confidentiality guidance to Clinical Review Team</td>
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<td>27.10.14</td>
<td>CS receives FoAHSW documentation</td>
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<td>03.11.14</td>
<td>FoAHSW documents &amp; CS process, governance and guidance dispatched to</td>
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<td>03.11.14</td>
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<td>14.11.14</td>
<td>24.11.14 Clinical Review Team Meeting</td>
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<td>11.12.14</td>
<td>Clinical Review Team – report writing</td>
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<td>12.01.15</td>
<td>Draft report to sponsoring organisation for fact checking</td>
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<td>19.01.15</td>
<td>Report to Clinical Senate Council</td>
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<td>26.01.15</td>
<td>(?Virtual) Clinical Senate Council meeting - for formal endorsement of</td>
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<td>02.02.15</td>
<td>Submit final report to sponsoring organisation</td>
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<td>Publish and disseminate as per terms of reference</td>
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4. Methodology

The role of the review team will be to examine documentary evidence, carry out site visits if necessary and decide recommendations. The West Midlands Clinical Senate acknowledges that the sponsoring organisations (NHS South Worcestershire CCG, NHS Redditch & Bromsgrove CCG and NHS Wyre Forest CCG), have undergone a first stage assurance process as a component of the NHS England assurance.

The Future of Acute Hospital Services in Worcestershire – West Midlands Clinical Senate Stage 2 Clinical Assurance Report – Version 4.0 (Status: Final)
process and is now ready to undertake a 2\textsuperscript{nd} stage assurance external expert review as part of the FoAHSW review programme (see Appendix 4 NHS England Assurance process).

The 2\textsuperscript{nd} stage 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 CCGs via the Future of Acute Hospital Services in Worcestershire 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 be over three days and will take place on the following dates:

- 17\textsuperscript{th} November 2014
- 24\textsuperscript{th} November 2014
- 11\textsuperscript{th} December 2014

The clinical review team will need to consider the following:

- is there robust evidence underpinning both the clinical case for change and the proposed clinical model? Documentation should include the case for change, proposed clinical models and relevant activity information.
- 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/corrections must be received within five working days.

The Clinical Review Team will submit a draft report (see Independent Clinical Review Team Report Template appendix 3) 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 sponsoring organisation by 2\textsuperscript{nd} February 2015, and the clinical advice will be considered as part of the NHS England Arden, Herefordshire and Worcestershire Area Team 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.

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 will handle all media inquiries in the first instance. The Clinical Senate may engage in various activities with the sponsoring organisation 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.

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.

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

9.1. The sponsoring organisation 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 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.

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 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 a 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 the 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 that materialise during the review.
TOR Appendix 1

Declaration of Conflict of Interest

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

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 that cannot be given a monetary value (for example, a reconfiguration of hospital services that 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 that 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

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<tr>
<td>Type of Interest</td>
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<td>Details</td>
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<td>Action Taken</td>
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<td>Action Taken By</td>
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<td>Date of Declaration</td>
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I hereby certify that the information set forth above is true and complete to the best of my knowledge.

Signature:

Name:

Date:
TOR Appendix 2

Confidentiality Agreement

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

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) ____________________________
TOR Appendix 3

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 AND 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 (NB this should be a summary and is not intended to be the set of evidence or information provided)
## 18 Appendix 2 ICRT Panel Members’ Biographies

### MEMBER BIOGRAPHY/PROFILE

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Helen Carter</th>
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<tr>
<td></td>
<td>Consultant in Public Health (healthcare), Public Health England</td>
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<td></td>
<td>Chair of the Independent Clinical Review Team</td>
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### BRIEF INTRODUCTION

Helen Carter graduated from Birmingham University Medical School and then spent a number of years in clinical medicine including General Practice, Neonatology and Accident and Emergency before moving into Public Health in 2001.

She has had a diverse portfolio including working in Health Authorities, Primary Care Groups/Trusts, academia, Health Protection Agency and Strategic Health Authority (SHA). Her topics of interest have included diabetic retinopathy screening, immunisations, sexual health and emergency planning, preparedness and response. She was the SHA emergency planning lead during H1N1 (swine flu) and the Olympics.

She joined Public Health England when this was created on 1st April 2013 as a Consultant in Public Health (Healthcare). She provides public health advice to commissioners, both directly through NHS England and indirectly to CCGs in partnership with her local authority Public Health colleagues.

Her current portfolio includes being the PHE Centre Executive Team lead for children and young people. She currently chairs a number of local and national networks including the West Midlands Healthcare PH network and the national network of PHE Centre Healthcare PH Consultants.

### MEMBER BIOGRAPHY / PROFILE

<table>
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<tr>
<th>Name</th>
<th>Dr Eleri Adams</th>
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<td>Independent Clinical Review Team Member</td>
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### BRIEF INTRODUCTION

Eleri Adams is Clinical Director and Consultant Neonatologist at Oxford University Hospitals, Oxford. She has been lead clinician for Thames Valley Neonatal Network since 2003, and has overseen the implementation of a 24 hour network transport service as well as the development of a more centralised model of care within the region. She is the Vice-Chair of Neonatal Clinical Reference Group (CRG) for NHS England. She is particularly interested in organisation of neonatal care, quality improvement initiatives for neonatal care and leads the CRG work stream for CQUIN development. She is also involved in research to further understand the development of pain pathways and pain processing in the newborn.
## MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Dr Deepti Alla</th>
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<td>Independent Clinical Review Team Member</td>
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### BRIEF INTRODUCTION

Dr Deepti Alla is a General Practitioner from Doncaster. She has experience working in various General Practice settings and understands the diverse needs of varied population groups. She continues to be involved in setting up services for effective delivery of healthcare at her surgery. She has a keen interest in education. Dr Alla is a GP Tutor for the University of Sheffield and GP Trainer for Yorkshire and Humber Post Graduate Deanery.

As a General Practitioner, Dr Alla has experience in undertaking the complex and difficult tasks that remain essential to socially inclusive and cost-effective healthcare.

## MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Mr Paul Byrne</th>
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<td>Independent Clinical Review Team Member</td>
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### BRIEF INTRODUCTION

Paul Byrne is the Director of Operations for the Division of Women and Children at the Gloucestershire Hospitals NHS Foundation Trust. He has more than 27 years’ experience of working as a senior manager in the NHS and was closely involved in the reconfiguration of children’s services and maternity services in Gloucestershire in 2006 and 2011. He has previously worked in London and Kent.

## MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Ms Penny Brett</th>
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<td>Independent Clinical Review Team Member</td>
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### BRIEF INTRODUCTION

Penny Brett is a registered Nurse and Midwife with more than 20 years’ NHS experience. Penny has been Head of Midwifery at Peterborough and Stamford Hospital for the past five years, during which time she has undertaken secondments as General Manager for Women’s and Children’s and Assistant Director of Nursing. Previous to this, Penny held several Consultant Midwife roles at Addenbrooke’s Hospital and Lewisham Hospital. Penny is currently a member of the East of England Clinical Senate Council.
MEMBER BIOGRAPHY/PROFILE

| Name                  | Mr Richard Corder  
|-----------------------|--------------------
|                        | Independent Clinical Review Team Member (Lay Representative) |

**BRIEF INTRODUCTION**

Richard Corder followed a career in insurance and sales. In 2001 he was diagnosed with Hypertrophic Cardiomyopathy and Atrial Fibrillation. This brought with it a change in attitude and lifestyle. Surgery and the fitting of a pacemaker followed.

He found working difficult and reduced to working a couple of days a week before retiring early in 2012. The NHS had been there for Richard when he most needed it and he decided to help it and his fellow patients. He believes his own experiences led him to try to help others get the care everyone deserves.

Richard is one of the organisers of the Thames Valley Cardiomyopathy Support Group, a Member of Council of the Cardiovascular Care Partnership and a Patient Representative with The Thames Valley Strategic Clinical Network.

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MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Mr Edward Davis</th>
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**BRIEF INTRODUCTION**

Edward Davis was appointed as a Consultant Orthopaedic Surgeon at The Royal Orthopaedic Hospital in 2007 in the hip and knee arthroplasty unit. He undertakes primary and revision hip and knee replacements at The Royal Orthopaedic Hospital and also has sessions at Russells Hall Hospital in Dudley where he undertakes primary joint replacements and undertakes an on-call trauma commitment.

He graduated from Birmingham University in 1996 and undertook basic and higher surgical training in the West Midlands. He undertook a year’s fellowship in revision hip and knee arthroplasty in Toronto, Canada.

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

He is actively involved in education as an honorary Senior Clinical Lecturer and Senior Clinical Examiner at The University of Birmingham. He is 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.
MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Dr Alistair Douglas</th>
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<td>Independent Clinical Review Team Member</td>
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BRIEF INTRODUCTION

Alistair is Consultant Physician (Acute Medicine and Nephrology) at Ninewells Hospital and Medical School, NHS Tayside.

He qualified from Queen’s University Belfast in 1986 and undertook postgraduate training in Belfast and Edinburgh before his first Consultant appointment in 1999 at Conwy and Denbighshire NHS Trust, North Wales, prior to moving back to Scotland in 2007.

He is President of the Society for Acute Medicine (SAM). Formed in 2000, SAM was established at a time when the concepts of acute medicine and the Acute Medical Unit (AMU) were in their infancy. Since that time things have moved forward considerably – most hospitals now have an AMU and acute medicine has been approved as a specialty in its own right. Large numbers of specialist acute physicians have been appointed to drive forward changes in the management of patients on the AMU, and several hundred specialist registrars are now training on the newly approved Curriculum in Acute Internal Medicine. SAM has played a pivotal role in many of these developments and is represented on many national committees enabling a strong voice for acute physicians within the Royal Colleges and other key organisations. For further information visit www.acutemedicine.org.uk.

MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Prof Ian Greaves</th>
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<td>Independent Clinical Review Team Member</td>
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BRIEF INTRODUCTION

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. He has fellowships from the Colleges of Physicians, Emergency Medicine and Surgery and in Immediate Care and is a Fellow of both the Royal Society of Arts and Royal Geographical Societies. Since 2002, He has been Consultant in Emergency Medicine at James Cook University Hospital in Middlesbrough. He was appointed to a visiting professorship in emergency medicine at the University of Teesside in 2003. In civilian life, He leads the Academic Department of Emergency Medicine at the University of Teesside and James Cook Hospital. He has published widely in the fields of trauma, pre-hospital care and military medicine and edits the quarterly journal Trauma. He has also written or edited a number of textbooks including key texts in the field of Immediate Care and paramedic practice and contributed to a wide range of other books. He is a member of the Executive and...
Faculty Board of the Faculty of Pre-Hospital Care and the secretary of the charity Trauma Care and recently served on the Department of Health Clinical Advisory Group on Pre-Hospital and Transfer Medicine. He was Defence Consultant Advisor in Emergency Medicine, responsible for co-ordinating the delivery of an emergency medicine capability and Pre-Hospital Care, including the emergency response helicopter in the UK and on operations in Afghanistan for six years until 2014 and has deployed to both Iraq and Afghanistan. From 2010 to 2014 he was Honorary Surgeon to HM Queen Elizabeth II.

MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Dr Jeremy Groves</th>
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<td>Independent Clinical Review Team Member</td>
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**BRIEF INTRODUCTION**

Jeremy Groves has been a Consultant in Anaesthesia and Intensive Care Medicine at the Chesterfield Royal Hospital since 1995. He is Clinical Lead for the North Trent Critical Care Network and is on the Council of the Intensive Care Society. He has worked with the examinations department of the Royal College of Surgeons since 1999 and latterly the Intercollegiate Committee for Basic Surgical Examinations in Quality Assurance.

MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Mr Athur Harikrishnan</th>
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<td>Independent Clinical Review Team Member</td>
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**BRIEF INTRODUCTION**

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 four 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 Lectureship with Edge Hill University.

His managerial roles include Yorkshire chapter representative of the Association of Coloproctology of GB and Ireland and member of the Yorkshire and Humber Clinical Senate.
MEMBER BIOGRAPHY/PROFILE

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<th>Name</th>
<th>Ms Beverly Ingram</th>
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**BRIEF INTRODUCTION**

Beverly is an experienced Chief Nurse and is currently Executive Director of Nursing for Birmingham Community Health Care NHS Trust (BCHC). Having been a nurse for 34 years she has gained experience within a number of health organisations working as a nurse, senior nurse and executive nurse.

Beverly currently provides a leadership role for nurses and allied health professionals within BCHC and manages an organisational-wide portfolio consisting of clinical education, training, patient experience, clinical governance and patient safety and safeguarding.

Beverly has participated in or led on a number of service reviews and redesigns and developments of clinical services. She has studied locally and internationally and completed a number of leadership programmes including the Kings Fund leadership programme and the aspirants chief executive programme.

With a passion for leading services that deliver the best possible patient care Beverly is an advocate for quality improvement and the experience patients have when they receive care from NHS teams.

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MEMBER BIOGRAPHY/PROFILE

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<tr>
<th>Name</th>
<th>Mr Duncan Learmonth</th>
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<td>Independent Clinical Review Team Member</td>
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**BRIEF INTRODUCTION**

Mr Duncan Learmonth graduated at Birmingham University in 1982. He undertook orthopaedic training in Leicester, West Midlands and Adelaide, Australia. He was appointed Consultant Orthopaedic Surgeon in 1993. His post was in Trauma and Orthopaedics at the Birmingham General Hospital and the Royal Orthopaedic Hospital in Northfield, Birmingham. His role was managing major trauma cases and his specialist interest is knees and shoulders. Duncan Learmonth left the NHS in 2007 and has been in private practice dealing with knee and shoulder orthopaedic pathologies since that time. Currently he is the Chairman of the Medical Advisory Committee at the Priory Hospital dealing with issues of governance and provision of clinical services.

He is involved in teaching on the Specialist Registrar programme in the West Midlands and other Deaneries and regularly participates in local and national conferences regarding knee and shoulder pathology. He is also involved in teaching specialist registrars and Consultants in techniques of arthroscopic surgery.
MEMBER BIOGRAPHY/PROFILE

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<th>Name</th>
<th>Dr Jackie McLennan</th>
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BRIEF INTRODUCTION

Jackie McLennan trained at Leicester University and qualified as a doctor in 1998. Following this she has had a varied career with 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. This training was interspersed with deployments to Northern Ireland, Kosovo and Iraq. Her training as a Registrar was based initially at the James Cook University Hospital, Middlesbrough, before moving to the North Western Deanery where she trained at 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. There she has been part of a team developing the massive transfusion protocols across the region, been the Emergency Department lead on major trauma, and has finished her research degree on production of a clinical decision rule to help guide people on the need for massive transfusion in major trauma. She has also been deployed twice to Afghanistan.

MEMBER BIOGRAPHY/PROFILE

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<th>Name</th>
<th>Dr Peter-Marc Fortune</th>
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BRIEF INTRODUCTION

Peter-Marc began his career as an engineer. After reading electronics at university and a spell working for the BBC, he undertook a period of research into mobile telephony, culminating in the award of a PhD. Subsequently he decided on an alternative career path and, in 1988, he secured a place to study medicine.

By his fifth year Peter-Marc had developed a clear passion for paediatrics and following house jobs he proceeded directly on to a paediatric training rotation. A career in Paediatric Intensive Care (PIC) Medicine became an early goal. After completing his postgraduate professional examinations in Paediatrics he undertook basic Anaesthetic training to sharpen his skills for PIC.

He moved to North London for his registrar rotation undertaking general paediatric training at Northwick Park Hospital followed by PIC training at Great Ormond Street Hospital. His final year of training was undertaken in PIC at the Royal Children’s Hospital, Melbourne, where he was chief registrar for the majority of the year.

Peter-Marc’s first Consultant position was as a foundation Consultant on the brand new...
London-based, Children’s Acute Transport Service (CATS). From there, in 2002, Peter-Marc joined the PIC team, at Royal Manchester Children’s Hospital, the biggest and busiest children's hospital in the country. The team in Manchester was in the early phases of designing a new children’s hospital. In 2005 he was appointed Clinical Director of Critical Care. In this role he has undertaken a major role in the design, planning and delivery of the new hospital building and services (opened in 2009). He also led the commissioning and launch of the North West and North Wales paediatric transport Service (NWTS) and led the development of the national Paediatric and Neonatal Safe Transfer and Retrieval (PaNSTaR) course for the Advanced Life Support Group (ALSG).

Peter-Marc’s most recent passion is the pursuit of patient safety. He has taken a particular interest in Human Factors (HF), the non-technical skills that affect human performance. He co-led a team that facilitated a review programme looking at patient deterioration events that resulted in a 25 per cent reduction of cardiac arrests within his trust. Outside of the trust he has written new HF chapters for the ALSGs training manuals and the latest version of the ABC of Resuscitation. He also chairs the ALSGs HF working group, which has developed a course to embed training within the ALSG’s training courses and educational materials that have been made freely available to support wider training.

Peter-Marc was appointed to the post of Associate Clinical Head of Royal Manchester Children’s Hospital in 2012. He has also been the Director of Resuscitation and Simulation Services for Central Manchester Hospitals NHS Foundation Trust since 2006. He is Vice President of the Paediatric Intensive Care Society (UK), the Chair of Making it Safer Together (MiST, a paediatric patient safety collaborative) and a trustee of the Advanced Life Support Group. He has recently completed six years of service on the executive committee of the Resuscitation Council (UK). He has interests in Medical Education and Medical Ethics. He holds an MA in Medical Ethics and Law and has written and contributed to a number of publications on end-of-life issues.

MEMBER BIOGRAPHY/PROFILE

Name  | Ms Andrea Pope-Smith  
Independent Clinical Review Team Member

BRIEF INTRODUCTION
Andrea Pope-Smith has been a Director of Adult Social Services for 10 years, with responsibility for a wide range of council services, working in the West Midlands and Yorkshire and Humber regions. She has played an active role within ADASS regionally and currently is the joint national lead for ADASS on Learning Disability, and the national lead for ADASS in response to Winterbourne View.
MEMBER BIOGRAPHY/PROFILE

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<th>Name</th>
<th>Mr Peter Sedman</th>
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<tr>
<td>BRIEF INTRODUCTION</td>
<td>Peter Sedman is an upper Gastrointestinal Surgeon and has been a practising Consultant in Hull for 17 years. His main interest is in laparoscopic ('keyhole') abdominal surgery in which he has held several positions and is the President Elect of the Association of Laparoscopic Surgeons of Great Britain and Ireland. He serves as the Yorkshire representative on NHS England's upper gastrointestinal clinical reference group.</td>
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MEMBER BIOGRAPHY/PROFILE

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<th>Name</th>
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<td>BRIEF INTRODUCTION</td>
<td>Mr Rashid Sohail is the Interim Medical Director at East Midlands Ambulance Service (EMAS) NHS Trust. Rashid has worked for the EMAS since 2013 and is currently its Responsible Officer and Caldicott Guardian. He was first appointed as a Consultant in Emergency Medicine (with sub-interest in acute hand trauma surgery) in 2000 and has subsequently held joint appointments as Clinical Director of Emergency Medicine and Chief of Division of Medicine in the NW. Rashid is a GMC Specialist Registration Appeals Board Member. Rashid has a keen interest in medical education particularly the interface between medicine and the law. He is an examiner for the College of Emergency Medicine for both MCEM and FCEM and has recently been appointed as an OSCE examiner for Manchester University Medical School. Rashid is an Assistant Coroner in the City of Manchester Jurisdiction and has held this appointment since 2008. He has an interest in how NHS organisations can learn from coronial inquests and how that learning is subsequently translated into organisational improvements. Rashid is a member of National Ambulance Service Medical Directors (NASMeD) group. He has been helping to develop a national ambulance service database of all Prevention of Future Death Reports issued to Ambulance Services in England and Wales. This database will help to facilitate the issuing of national advice and guidance to the ambulance services in order to improve patient care and clinical safety.</td>
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MEMBER BIOGRAPHY/PROFILE

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<th>Name</th>
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<td>Independent Clinical Review Team Member</td>
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**BRIEF INTRODUCTION**

Ian Sugarman is a Consultant Paediatric and Neonatal Surgeon at Leeds Teaching Hospital NHS Trust, having been in post since November 1999. He trained in Paediatric Surgery in Southampton General Hospital and Great Ormond Street Hospital for Children, London.

He has been Honorary Secretary (2010-13) of the British Association of Paediatric Surgeons and is presently the Honorary Treasurer.

He has been/is involved in various paediatric working groups including Intestinal Failure, Inflammatory Bowel Disease and Endoscopy.

He has previously worked in Hull, Nottingham, Portsmouth and Bournemouth as well as Southampton, London and Leeds. He has worked in cities where services were split and has been in Leeds while service provisions have been reconfigured between the hospitals within Leeds.
19 Appendix 3 Declaration of Interests

Duncan Learmonth takes part in FCN/Choose and Book work/NHS waiting list initiatives at BMI Priory Edgbaston Hospitals.

Beverley Ingram: no current personal relationships or transactions for Acute Hospital Services in Worcester other than the Director of Nursing is a colleague of mine within the nurse directors’ network. I also provide coaching to one of the more junior managers from Worcester Acute.

Alistair F Douglas: President for the Society For Acute Medicine.

Edward T Davis: Consultant at Royal Orthopaedic Hospital, Birmingham. I also work at the Russells Hall Hospital in Dudley and the West Midlands Hospital in Dudley, Director of Research and Development at Royal Orthopaedic Hospital, Birmingham.

No other declarations of interest were declared by the ICRT.
# 20 Appendix 4 ICRT Agenda Day 1

**DAY 1**

Independent Clinical Review Panel  
Future of Acute Hospital Services Worcester (FoAHSW)  
Monday 17th November, 10.00 am until 4.30 pm  
Venue – Novotel, 70 Broad Street, Birmingham B1 2HT

**AGENDA**

<table>
<thead>
<tr>
<th>Timing</th>
<th>Item</th>
<th>Evidence</th>
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<tbody>
<tr>
<td>10.00</td>
<td>1</td>
<td>Arrival with Refreshments and Panel Pre-meet</td>
</tr>
<tr>
<td>10.30</td>
<td>2</td>
<td>Declaration of Interest and Confidentiality Agreement</td>
</tr>
<tr>
<td>10.40</td>
<td>3</td>
<td>Introduction from Chair</td>
</tr>
<tr>
<td>10.50</td>
<td>4</td>
<td>Setting the Scene</td>
</tr>
<tr>
<td>11.20</td>
<td>3</td>
<td>Session 1: Introduction and review of information submitted</td>
</tr>
<tr>
<td>12.30</td>
<td>5</td>
<td>Lunch</td>
</tr>
<tr>
<td>1.00</td>
<td>6</td>
<td>Session 2: Presentation – Detail of Reconfiguration</td>
</tr>
<tr>
<td>1.45</td>
<td>7</td>
<td>Questions</td>
</tr>
<tr>
<td>2.30</td>
<td>8</td>
<td>Refreshment Break</td>
</tr>
<tr>
<td>2.50</td>
<td>9</td>
<td>Session 3: Review and Discussion</td>
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<tr>
<td>4.00</td>
<td>10</td>
<td>Session 4: Deliberations and Next Steps</td>
</tr>
<tr>
<td>4.30</td>
<td>11</td>
<td>End</td>
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</table>
21 Appendix 5 ICRT Agenda Day 2

DAY 2
Independent Clinical Review Panel
Future of Acute Hospital Services Worcester (FoAHSW)
Monday 24th November, 10.00 am until 4.30 pm
Venue – Alexandra Hospital, Woodrow Drive, Redditch, B98 7UB
Worcestershire Royal Hospital, Charles Hastings Way, Worcester, WR5 1DD

AGENDA

<table>
<thead>
<tr>
<th>Timing</th>
<th>Item</th>
<th>Evidence</th>
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<tbody>
<tr>
<td>9.45</td>
<td>1</td>
<td>Arrival &amp; Refreshments</td>
</tr>
<tr>
<td>10.00</td>
<td>2</td>
<td>Welcome and Introduction</td>
</tr>
<tr>
<td>10.10</td>
<td>3</td>
<td>Declaration of Interest</td>
</tr>
<tr>
<td>10.15</td>
<td>4</td>
<td>Review of Day 1 – 17th November</td>
</tr>
<tr>
<td>10.30</td>
<td></td>
<td>Welcome from the Chair &amp; Chief Executive of Worcestershire Acute Hospitals NHS Trust</td>
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<tr>
<td>10.40</td>
<td>5</td>
<td>Tour of Alexandra Hospital</td>
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<td></td>
<td></td>
<td>Group 1  A&amp;E</td>
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<tr>
<td></td>
<td></td>
<td>Group 2  Critical Care/Surgery</td>
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<td></td>
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<td>Group 3  Paediatrics</td>
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<td></td>
<td></td>
<td>Group 4  Obstetrics &amp; Neonates</td>
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<td></td>
<td></td>
<td>Panel members will split into relevant groups of their speciality and interest. Each group will meet Lead Consultants, Nurses and Doctors from the Trust who will walk through the proposed model for the service. Time for Q&amp;A will be made available.</td>
</tr>
<tr>
<td>12.40-1.10</td>
<td>7</td>
<td>Lunch</td>
</tr>
<tr>
<td>1.20-1.50</td>
<td>8</td>
<td>Travel to Worcestershire Royal Hospital via minibus (please note: shuttle to Alexandra Hospital, Redditch will be available throughout the afternoon)</td>
</tr>
<tr>
<td>Time</td>
<td>Event Description</td>
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<tr>
<td>2.05</td>
<td>Welcome and Introduction</td>
<td></td>
</tr>
<tr>
<td>2.15</td>
<td>Focus Group Arrangement</td>
<td></td>
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<tr>
<td>2.15</td>
<td>Tour of Worcestershire Royal Hospital</td>
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<tr>
<td>Group 1</td>
<td>A&amp;E</td>
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<tr>
<td>Group 2</td>
<td>Critical Care/Surgery</td>
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<tr>
<td>Group 3</td>
<td>Paediatrics</td>
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<tr>
<td>Group 4</td>
<td>Obstetrics &amp; Neonates</td>
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<tr>
<td>Programme Team Leads accompanied by a Directorate Manager to lead the tour, GP Quality Lead and Task &amp; Finish Group Chair.</td>
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<tr>
<td>4.15</td>
<td>Panel Discussion</td>
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<tr>
<td>4.45</td>
<td>CLOSE</td>
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<tr>
<td>5.00</td>
<td>Final Shuttle Bus to Alexandra Hospital, Redditch</td>
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# 22 Appendix 6 ICRT Agenda Day 3

**DAY 3**

Independent Clinical Review Panel  
Future of Acute Hospital Services in Worcestershire (FoAHSW)  
Thursday 11th December, 10.00 am until 4.30 pm  
Venue: The ICC, Symphony Hall, Broad Street, Birmingham, B1 2EA  

## AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
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</thead>
<tbody>
<tr>
<td>9.30</td>
<td>1. Arrival &amp; Refreshments</td>
<td></td>
</tr>
<tr>
<td>10.00</td>
<td>2. Welcome &amp; Declarations of Interest</td>
<td>Helen Carter, Chair</td>
</tr>
<tr>
<td>10.15</td>
<td>3. Review of Day 2 – 24th November 2014</td>
<td>All</td>
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<tr>
<td></td>
<td>To review the questions from panel members, and provide responses in accordance to any additional queries.</td>
<td>Mark Wake; Graham James; Cathy Garlick</td>
</tr>
<tr>
<td>11.15</td>
<td>4. Presentation: A&amp;E and Urgent Care</td>
<td>Carl Ellson Clinical SRO and lead GPs Marion Radcliffe, Sally Rumley</td>
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<td>To understand the current ‘networked’ Emergency Centre pilot, implemented at AH and WRH, and</td>
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<td></td>
<td>Receive assurance of the ED GP and Consultant workforce requirements to develop and implement future models</td>
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<td></td>
<td>Urgent Care Strategy for Worcestershire and local implications for both AH and WRH sites</td>
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<td></td>
<td>- Emergency</td>
<td></td>
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<td></td>
<td>- Paediatrics / Obstetric</td>
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<tr>
<td></td>
<td>WMAS Lead CCG Commissioner Position</td>
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<tr>
<td>12:15</td>
<td>6. Deliberation</td>
<td>All</td>
</tr>
<tr>
<td>12.45</td>
<td>7. Lunch</td>
<td></td>
</tr>
<tr>
<td>13:30</td>
<td>8. Feedback to FoAHSW Programme Board</td>
<td>All (Lucy Noon &amp; Simon Hairsnape)</td>
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<tr>
<td>14:00</td>
<td>9. Report Writing</td>
<td>All</td>
</tr>
<tr>
<td>16:30</td>
<td>10. Close</td>
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## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
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<tbody>
<tr>
<td>11.15</td>
<td>1. Arrival &amp; Refreshments</td>
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<tr>
<td>11.30</td>
<td>2. Welcome &amp; Declarations of Interest</td>
<td>Helen Carter, Chair</td>
</tr>
<tr>
<td>11.40</td>
<td>3. Emergency Medicine Sub-group Session</td>
<td>Helen Carter (CHAIR)</td>
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<td></td>
<td>ED Physicians to meet with key panel members to discuss the A&amp;E Model and their concerns, in private.</td>
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<tr>
<td>13.00</td>
<td>4. CCG Meeting</td>
<td>Helen Carter (CHAIR) Worcester CCG representatives</td>
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<tr>
<td>13.30</td>
<td>5. PRIVATE: Panel Deliberation Over Lunch</td>
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<tr>
<td>14.00</td>
<td>6. TBC: Teleconference with Nigel Beasley, Chair of ICRP (Nov/Dec 2013), James Davidson, ED Consultant, and Iain Lennon, ED Consultant</td>
<td>Helen Carter (Chair)</td>
</tr>
<tr>
<td>14:30</td>
<td>7. Feedback and Q&amp;A</td>
<td>ALL</td>
</tr>
<tr>
<td>15:15</td>
<td>8. Final Summary and Outline Recommendations</td>
<td>Panel Members, and Lucy Noon</td>
</tr>
<tr>
<td>15.45</td>
<td>9. CLOSE</td>
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