

Reconfiguration of hospital services

A programme to sustain services and improve care

Appendix 10 – Clinical Assurance

As referred to in Chapter 10



Detailed Clinical Senate responses

Senate Panel 1 – June 2016

Clinical Senate 1 Recommendations	STP Response
1. Consider more radical options	<ul style="list-style-type: none"> • More radical alternatives – such as further reducing emergency services on Southend site - considered by ALG
2. Consider the impact of interdependencies with neighbouring organisations	<ul style="list-style-type: none"> • The impact on other organisations and STPs has been considered, and is outlined in Section 6
3. Assess the impact of acute reconfiguration on patient transport	<ul style="list-style-type: none"> • Detailed, effective conveyance protocols will be developed to ensure safe transfer of patients • a detailed travel time analysis for each reconfiguration option has been undertaken, although revised proposals mitigate this to a large extent. The full results of this are available in Appendix 11
4. Assess the impact of acute reconfiguration of patient volumes in each trust	<ul style="list-style-type: none"> • Detailed activity modelling has been conducted to ensure the options can fit onto the current site and/or are complemented by a clear capital programme.
5. Clearly define success metrics for the STP	<ul style="list-style-type: none"> • Success metrics have been defined for the STP as part of the national framework. Individual specialties will be asked to consider development of outcome metrics
6. Develop more detail on connections between frailty, long-term conditions and palliative care	<ul style="list-style-type: none"> • The STP established a working group to develop new best practice pathways in these areas, and now has an agreed system wide blueprint
7. Develop clear communications strategy to educate patients and staff	<ul style="list-style-type: none"> • There is a comprehensive approach to communications and engagement. Section 12 details the work to date • The STP will develop appropriate sign-posting to ensure all members of the public are well-informed about the changing provision of healthcare in mid and south Essex
8-10. Develop a clear organisation development and workforce strategy	<ul style="list-style-type: none"> • A clinical leadership programme, facilitated by Prof. Richard Bohmer, will be rolled out across the three sites to establish ongoing process of clinical transformation • This is intended to develop into an STP Quality Improvement Academy

Senate Panel 2 – October 2016

Clinical Senate 2 Recommendations	STP Response
<p>1. The mid and south Essex STP should reconsider its pace of change</p>	<ul style="list-style-type: none"> • Subsequent to the Clinical Senate and the options appraisal process, the STP has delayed the submission of the PCBC and entered a renewed engagement phase to allow more detailed discussion. This led to further changes to the proposed model, for example in relation to A&E
<p>2. The STP should look to be more bold and ambitious in its proposals.</p>	<ul style="list-style-type: none"> • The STP has fed back this challenge and pushed work-streams to consider "hard" options, as well as "soft" and "medium" • This feedback was presented as part of the Options Appraisal process in March, which included independent clinical input and review of the proposed solutions and was balanced against feedback from engagement sessions (many of which expressed concern over more radical solutions)
<p>3. The STP should look to strengthen its case for change with clear system wide and service specific ambitions</p>	<ul style="list-style-type: none"> • The STP is now working to better clarify and communicate the overall vision of the STP • The Case for change section of the PCBC has been considerably strengthened, and has been considered and agreed by local Boards • The workforce challenge is being specifically reviewed and EAHSN have assessed likely impact on outcomes
<p>4. The STP should undertake predicted activity modelling and analysis for the preferred model to ensure that physical, workforce and access capacity would be sufficient to meet demand at all times of the day and year on all sites</p>	<ul style="list-style-type: none"> • Extensive activity modelling for the acute reconfiguration options has already been undertaken. This includes an analysis of the impact of reconfiguration on requirements for hospital beds, operating theatres, and A&E attendances. • High level workforce requirements are now being developed for each specialty; more detailed implementation plans will be developed post-consultation
<p>5. The STP should undertake full modelling, impact analysis and risk assessments for access and transport, working with both the Ambulance Trust and County Council to ensure appropriate and adequate provision</p>	<ul style="list-style-type: none"> • A detailed travel time analysis has been performed to understand the impact of reconfiguration on patient access. • The STP has established a specific transport sub-group, and continues to work closely with EEAST and local authorities to model the impact of acute reconfiguration on ambulance provision and patient

Clinical Senate 2 Recommendations	STP Response
	transport.
6. The STP should develop a communication strategy for the public, patients, staff and other stakeholders	<ul style="list-style-type: none"> Although it was not shared with the clinical senate, a communications strategy has been developed, and is described in this PCBC
7. The STP should have well developed robust pathways for patient flow and transfer	<ul style="list-style-type: none"> High level patient pathways have been developed by each workstream to demonstrate the future model of care The third Senate review will consider these pathways, which have been developed following the revised clinical model

General recommendations

Clinical Senate 2 Recommendations	STP Response
1. The panel urged the team to give consideration to more radical options particularly for urgent and emergency care but also for obstetric care and paediatrics. The panel felt in particular that some of the proposals were neither "here nor there" i.e. offering more than a walk in centre but not a full Emergency Department service.	<p>More radical models have been considered</p> <ul style="list-style-type: none"> For urgent and emergency care the model now considers an option where the A&E at the specialist elective centre accepts only minors arriving by ambulance and short-stay admissions, therefore protecting elective services The paediatric subgroup have considered three phases, with the final phase including a specialist children's hospital, with consolidation on one site of all complex paediatric surgery and medicine and redirection of ambulances For maternity a standalone Midwife Led Unit was considered. While it is not thought that it is a feasible model, other models of OLU have been considered which would enable a different model of neonatal care.
2. Further work and detail is required on the impact of interdependencies with partner and periphery organisations and also on unexpected patient flow, including the impact on transport.	<ul style="list-style-type: none"> The impact on other organisations has been considered in the section of the PCBC "strategic alignment of plans". This ensures that the mid and south Essex plans are aligned with specialised commissioning, and other STP areas. Flows off patch are being considered, in particular as part of the EEAST model for East of England as a whole
3. The panel recommended, as a priority, the team should develop further detail on the impact of patient transport, that this be considered during clinical pathway development	<ul style="list-style-type: none"> The STP has established a cross agency sub-group to consider this in more detail The safe transfer of patients is a significant

Clinical Senate 2 Recommendations	STP Response
<p>at the earliest stages. Includes expected numbers but should include specifically the management of the transfer of critically ill patients from one site to another. Detail should include how transfers would be managed and coordinated, the impact on patients and relatives, particularly those who have mobility impairment and / or rely on public transport needs to be considered and addressed. The panel recommended that the team involve the Ambulance trust in that work from the start.</p>	<p>consideration for the STP. We are reviewing patient transfer protocols that have been used effectively elsewhere, and will develop Essex-specific transfer protocols as part of the ongoing work.</p> <ul style="list-style-type: none"> • EEAST have been part of the development of these plans, and work is ongoing with EEAST to understand the potential impact of each option • An equality impact assessment has been undertaken, with supporting travel time analysis • CCGs will review transport eligibility criteria in the light of this work, and we are in discussion with local authorities on options for patient transport, as they undertake a review of public transport offerings
<p>4. The panel felt that more modelling needed to be done taking into consideration changes in patient flows i.e. closing or moving some services would require large numbers of patients to go elsewhere. Modelling needed to inform pathway development to ensure the changes did not create capacity issues. This should include the impact on trusts on the periphery of the area</p>	<ul style="list-style-type: none"> • All current services will still be provided within mid and south Essex • The current modelling projects increased repatriation of mid and south Essex population to local services • Additional travel time analysis has been conducted to calculate the potential impact on other trusts of moving services (see travel time section) • Capacity modelling has been conducted to ensure the options can fit onto current site footprint (see capacity modelling section)
<p>5. The panel recognised that this was still early stages but recommended that the team start to define what they expect the implemented proposals to achieve in terms of improved outcomes, especially for patients. There needs to be clear definition of how and when and what will be measured.</p>	<ul style="list-style-type: none"> • Metrics for the impact of reconfiguration on outcomes, service levels, patient experience and choice have been defined by each subgroup • EAHSN have completed work on anticipated outcomes • Clinical teams have been considering desired outcomes in developing revised patient blueprints
<p>6. The panel recommended that more detail needed to be included on the connections between and the pathways for frailty, long term conditions and palliative care. Similarly there had been little detail on mental health provision and this needed to be factored into all pathways, particularly frailty, long term conditions and women's services</p>	<ul style="list-style-type: none"> • This was not shared at the Clinical Senate but an outline of the key local health and care pathways, and progress to date are included in the PCBC (section 5)

Clinical Senate 2 Recommendations	STP Response
<p>7. The team should develop a communication strategy, once proposed service and pathway changes are determined, to inform and educate patients, staff and media. There needs to be clarity and consistency with language and terminology to make sure services are understood</p>	<ul style="list-style-type: none"> • A communications strategy has been developed and an engagement process has been ongoing • An overview of the approach taken by the STP is included within the PCBC (section 12)
<p>8. The panel recommended that an organisational development strategy be developed as early as possible. The team had not made clear whether there were sufficient staff from all three sites to cover the proposed splits in service and agreed this needed to be detailed and recommended that the OD strategy should be informed by a detailed workforce analysis of both current position and the desired position, so that appropriate levels of staff are identified to increase capacity where it would be needed.</p>	<ul style="list-style-type: none"> • A clinical leadership programme is already underway at Basildon – this has been facilitated by Prof. Richard Bohmer. We are now rolling this out across the three sites to establish ongoing process of clinical transformation and are moving towards establishment of an STP Quality Improvement Academy
<p>9. The panel recommended that a detailed organisational development strategy be developed to cover the whole of the mid and south Essex health and social care system. This should include a change management strategy.</p>	<ul style="list-style-type: none"> • This recommendation is being considered by the STP Local Workforce Action Board and proposals for cross-system action are under development
<p>10. The panel further recommended that a detailed workforce plan was developed. This should include all relevant staff groups, current and predicted requirements and areas where there was a risk of a shortfall in workforce. Supporting strategies to the workforce plans should include recruitment and retention strategy, staff engagement and staff development strategies.</p>	<ul style="list-style-type: none"> • See response to 8 and 9
<p>11. The STP had explained that the Clinical and Professional Leaders Group had developed the options presented to the panel and that involvement of a wider clinician cohort was the next planned stage of development. The panel recommended that the STP</p>	<p>Many clinical leads are already involved in the development of the STP, although this was not fully described to Clinical Senate. Groups include:</p> <ul style="list-style-type: none"> • Professional Board, including local authority representatives • Senior Leadership Group, including all key organizations across the region • Clinical and Professional Leadership group,

Clinical Senate 2 Recommendations	STP Response
<p>demonstrate more active engagement with others in the health and social care system especially including local authorities and also other relevant bodies, to ensure that the proposals were system wide and that essential and fundamental elements of the system (e.g., social care) were considered as part of the pathway and model development.</p>	<p>including all key organizations across the region</p> <p>Clinical subgroups are also in place, and a process of broader system engagement is ongoing. Views from all of these groups have been taken in to account in developing the clinical models described in these materials</p> <p>The STP is introducing a system wide Clinical Cabinet in September 17 to provide a single forum for clinical scrutiny and debate</p>

Recommendations for Urgent and Emergency Care

Clinical Senate 2 Recommendations	STP Response
<p>12. The STP should review the options for urgent and emergency care and consider a more radical approach to its proposals</p> <ul style="list-style-type: none"> No particular model suggested 	<p>More radical models have been</p> <ul style="list-style-type: none"> For urgent and emergency care the model now considers an option where the A&E at the specialist elective centre accepts only minors arriving by ambulance and short-stay admissions, therefore protecting elective services Further more radical proposals such as the closure of the A&E or the reduction of hours has not been considered due to patient safety concerns The final model did not include these more radical proposals, based on stakeholder engagement and some clinical concerns
<p>13. Critical care needs to be considered throughout the proposals – this is in relation to both the capacity of Intensive Care Units, Critical Care outreach services and in relation to the ability to transfer critically ill patients from one site to another</p>	<ul style="list-style-type: none"> The provision of critical care services has been considered and capacity modelling undertaken
<p>14. The panel agreed there was a lack of hard data supporting the proposals and recommended that there needed to be more robust data capture and analysis. This should include the number of A&E attendances, including data for current attendance levels after midnight and ambulance arrivals by site. It should also include projected numbers. A review of postcode of past patients would help identify "catchment" area demand for urgent and emergency care services under</p>	<ul style="list-style-type: none"> Further analysis has been done to provide supporting evidence for the proposals. This can be found in the supporting evidence section of this pack. This includes catchment area analysis, activity rates, A&E attendances in- and out-of-hours, majors and minors, and ambulance arrivals, with projected and actual numbers, using postcode data to identify catchment areas for the reconfiguration options

Clinical Senate 2 Recommendations	STP Response
the new model	
<p>15. A detailed workforce model should be drawn up describing current and projected workforce, potential gaps, the approach taken to facilitate re-location, the impact of proposed options and approach to enhanced recruitment and retention.</p>	<ul style="list-style-type: none"> • An initial workforce model has been developed which will be refined post-consultation
<p>17. There will naturally be resistance from the public to any changes to local services and provision and the recommendation 7 was crucial to the success of the urgent and emergency care changes. The current terminology was confusing and the panel recommended that the terminology for the respective centres be consistent and clear i.e. that it says what it does and when it does it.</p>	<ul style="list-style-type: none"> • The revised proposals (which will see all three A&Es continuing to operate largely as they do today) move away from this description, reducing the scope for confusion

Recommendations for Women's Services

Clinical Senate 2 Recommendations	STP Response
<p>18. The STP should review its use of terminology, and ensure it applies current, common, accepted terminology consistently throughout its planning, evidence and information documents.</p>	<ul style="list-style-type: none"> • Terminology has been reviewed for maternity and uses the following definitions • Neonatal intensive care unit - NICU (L3) • Local neonatal unit – LNU (L2) • Special care baby unit – SCBU (L1)
<p>19. The options should include non-pregnancy related gynecology services and include detail on the interface between gynecology and obstetrics.</p>	<ul style="list-style-type: none"> • The women's workstream has expanded in scope to cover all women's services, so that interdependencies between gynecology and obstetrics can be addressed cohesively • Gynecology has been moved into the surgery group • In the final (post engagement) model, only limited changes to gynecology are proposed
<p>20. The panel recommended a more thorough data analysis regarding Maternity services and potential reconfiguration with pathway changes. The panel recommended the team should factor in the potential for unplanned unit closure and peak and trough activity as well as mean activity data should be</p>	<ul style="list-style-type: none"> • Further work has been conducted on transport services (see travel times section) to accurately estimate the impact on ambulance and transport services • The STP has decided not to adopt a freestanding midwifery led unit so impact on sites outside Essex will not be a factor

Clinical Senate 2 Recommendations	STP Response
<p>included in the analysis. The team should ensure it has modelled the impact on existing sites within and outside Essex if one site were to be closed or re-classified. The panel recommended that the team undertake more detail on transport time, particularly for rapid transfer and the impact on ambulance and transport services. The options would benefit from a simulation for rapid transfers at different times of day.</p>	<ul style="list-style-type: none"> • Further analysis has been conducted on peak and trough activity • In the final (post engagement) model, only limited changes to maternity are proposed
<p>21. The panel recommended that the team should undertake more thorough review and analysis of whether a stand-alone Midwifery Led Unit would be viable with particular focus on trying to determine the likely activity that would flow through it, taking into account the experience of similar units elsewhere in the country. Looking to national guidelines, the team should work up in more detail the pathways, training and staffing requirements to further assess the viability of a standalone MLU with the expected or planned number of users.</p>	<ul style="list-style-type: none"> • Further research has been conducted into the financial and clinical viability of a Midwifery Led Unit. This can be found in the supporting evidence section of this pack. • The STP has decided not to adopt a freestanding MLU in its final proposed model

Recommendations for Paediatrics

Clinical Senate 2 Recommendations	STP Response
<p>22. The STP should be clearer about co-location of paediatrics with obstetrics, neonatal care, paediatric assessment units and/or Children’s Emergency Department and general urgent and emergency care. Other inter-dependencies need to be considered and described. There needed to be a plan of access to care from pre-term to 16/18 across the geographical area.</p>	<ul style="list-style-type: none"> • The STP has taken into account key interdependencies and a number of options have been developed which detail the impact on obstetrics, neonatal, paediatrics and emergency department. Further work will be done to address the interdependencies between late adolescent and adult medicine • In the final (post engagement) model, only limited changes to paediatrics are proposed
<p>23. There needs to be more robust data on paediatric elective surgery, anesthetic cases and modelling of the impact on other specialities. It was concerned that some of the data used had been coding data rather than commissioning data and</p>	<ul style="list-style-type: none"> • HES data has been used for the MSESr models; we are confirming whether SUS data would lead to the same answers

Clinical Senate 2 Recommendations	STP Response
information	
24. More robust workforce modelling is required. Pathways and protocols should be developed to support the modelling and options	<ul style="list-style-type: none"> • Further analysis has been performed to develop a workforce baseline for paediatrics in each trust.

Recommendations for Surgery

Clinical Senate 2 Recommendations	STP Response
25. The team had recognised the need for community support and the panel recommended the team needed to work up the detail, protocols and pathways to support elective patient's return to community settings at the earliest opportunity to inform the overall model.	<ul style="list-style-type: none"> • The STP are developing integrated pathways that will deliver new models of care with early supported discharge to the community or home • These were not shared with clinical senate in October • In the final proposals, clue patient pathways/blueprints have been developed
26. The panel recommended the team should also work up the detail around the identified inter-dependencies and undertake detailed modelling regarding any options to potentially be taken forward.	<ul style="list-style-type: none"> • Detailed capacity modelling has now taken place to examine the impact of moving different specialties. The key conclusions are outlined in Section 6 of the PCBC
27. The panel recommended that detailed workforce modelling be undertaken. This should include staffing to support emergency rotas and to support elective work, including the detail around workforce.	<ul style="list-style-type: none"> • An initial workforce model has been developed, which will be refined post-consultation

Recommendations from the Senate Panel held on 18th September 2017 – Treat and Transfer Model (currently being considered by the programme)

Recommendation 1

Inter-hospital transfers: The panel accepted that clinical pathways were still to be fully developed for the inter-hospital transfers but agreed that much more work was required to demonstrate a robust model that would deliver safe, appropriate, high quality services for patients. This should include detailed activity modelling on numbers, medical and nursing workforce, training implications and required skills, governance and resilience. The panel recommended that the STP give serious consideration to the complexity and implications of running its own inter-hospital

transport service and should ensure that risks and benefits are suitably assessed against alternative options.

Recommendation 2

Whilst the panel agreed with the direction of travel, and it recognised that there was a need to progressively differentiate and develop services over time; the panel felt that the longer term plans could be bolder. Previous clinical review panels have recommended Mid and South Essex (Success Regime) STP to consider more radical change, over a longer period of time¹. This independent clinical review panel was of the same opinion and reiterated its recommendation to use this as an opportunity to take a longer term view on how to create greater opportunities for improved patient outcomes and experience and indeed greater opportunities for staff development and individual careers.

Recommendation 3

The panel recommended that much more work in the area of information technology was be undertaken in order to have in place reliable, safe, real time transfer of patient information, essential for delivery the proposed reconfiguration of services. This information should be included in as part of the patient pathway development and should include the bed management system.

Recommendation 4

The panel recommended that the team make clear the arrangements that would be in place to support staff to work across the sites for the 'one team' approach, for example regarding travel, relocation and training and development opportunities.

Recommendation 5

The panel recommended that further engagement with neighbouring STPs take place and that as pathways are developed, modelling includes potential impact on STPs and other stakeholders particularly the Ambulance Trust.

Recommendations from the Senate Panel held on 18th September 2017 – Stroke Services (currently being considered by the programme)

Recommendation 1

The panel did not feel that there was evidence to support the plan to provide thrombolysis on all three sites with subsequent patient transfers to a single Hyper Acute Stroke Unit, particularly as the six-hour post thrombolysis phase was the most unstable time for patients. The panel recommended that thrombolysis should be delivered either at or in close proximity to the proposed single Hyper Acute Stroke Unit.

Recommendation 2

The panel recommended that in developing its model of care, the MSE STP look to national guidelines and national and international best practice, particularly with reference to transfer of stroke patients. It advised the STP team that it would need to have a strong and very robust case developing any elements of the service that did not follow national guidelines.

Recommendation 3

The panel recommended that the STP team model the impact on acute medicine, A&E services, diagnostics and elderly care of having additional admissions for stroke including stroke mimics to the site hosting the Hyper Acute Stroke Unit.

Recommendation 4

The panel supported standardisation of the stroke pathway across the STP. The panel recommended that further work be undertaken on standardising the pathway for Early Supported Discharge and end of life care where appropriate.

Recommendation 5

The panel recommended that if proposals for a single HASU were to proceed, then further detailed modelling must be undertaken and the STP must engage with stakeholders to consider any impacts, not least the neighbouring STPs and Ambulance Trust. The panel further recommended that detailed work be undertaken to ensure appropriate governance structures and processes are put in place.

Recommendations from the Senate Panel held on 17th October 2017 (currently being considered by the programme)

Recommendation 1

The panel supported the 'one team' approach for a single stroke service across Mid and South Essex and recommended that the staff come under a single administrative centre to enable appropriate rotas and to ensure that capacity was maintained at all three sites.

Recommendation 2

The panel recommended that detailed modelling on a number of areas be undertaken. This should include modelling to:

- a. identify the appropriate size of the HASU to support the proposed model and the required number of step down stroke beds at each site, incorporating the percentage of patients with conditions that mimic strokes that would need to be admitted to each unit;

- b. model the appropriate size of a HASU for a single point of entry pathway to ensure this is considered during planning, especially of physical infrastructure and workforce, as this is a possible future state model of care depending upon the sustainability of workforce, patient outcomes and performance;
- c. identify the staffing required to support the in-patient beds at all three sites and the Emergency Department stroke reception team to support the assessment areas and inpatient beds;
- d. identify the capacity to manage and accommodate the subsequent repatriation of both actual stroke and stroke mimic admissions;
- e. identify the capacity of the Ambulance service for the additional two journeys per patient (move from local ED to HASU and subsequent repatriation). (NB recognising that an option for an inter-hospital transfer service was being considered); and
- f. note also the recommendation on modelling from the review panel of 18 September 2017.

Recommendation 3

The panel agreed that an established, robust Telemedicine service was crucial to the success of the non-core out of hours element of the three point access (drip and ship) model; the panel recommended that MSE STP team develop a clear timeline for the procurement, implementation and testing of the Telemedicine service.

Recommendation 4

The panel recommended that the MSE STP team incorporated ongoing reviews and appraisals (alongside the usual data collection); this would include monitoring transport times and the types and numbers of patients presenting with conditions that mimic strokes. This would help to ensure the outcomes were in line with expectations and, if necessary, future adjustments of the proposed model were made in a timely manner.