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APPENDIX 4A – CLINICAL SENATE REVIEW

NHS England

West Midlands Clinical Senate
Shropshire and Telford
Future Fit Programme

NHS England

Stage 1 Phase 1 Report

Independent Clinical Review Team Report v1.0 Final
Future Fit Programme – Shropshire and Telford

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1. Foreword by Panel Chair and Vice Chair - Mr Simon Brake and Mr Peter Thompson

This review was undertaken on behalf of the West Midlands Clinical Senate following a request from Shropshire CCG (Clinical Commissioning Group) and Telford & Wrekin CCG received in April 2014 to review the proposals for health care in Shropshire, Telford and Wrekin and to act ‘as a critical friend’. The report has been written on the basis of a wealth of information and evidence, as well as contributions and observations from a range of experts on the panel and from the Future Fit Programme. As this was a stage 1 clinical review, much of the report is based on broad proposals and plans, projections and a number of assumptions which will only be tested and probed as the plans progress and are implemented. Notwithstanding that, the information provided was comprehensive, and demonstrated a considerable amount of careful thought, public and professional engagement and ambition for the health and wellbeing of the community.

2. Clinical Senate Chair Summary and Recommendations – Dr David Hegarty

The West Midlands Clinical Senate was asked to provide informal advice and expert ‘critical’ challenge, to the service models being developed in the Future Fit: Shaping Healthcare Together programme as part of NHS England’s Stage 1 assurance process.

The Clinical Senate Review panel has concluded that there is an unsustainable health model across the Shropshire, Telford and Wrekin’s health and social care economy which warrants a need for fundamental change and improvement. Future Fit therefore, provides the opportunity to improve the quality of care provided to the Shropshire, Telford and Wrekin’s changing population.

The methodology utilised by the Clinical Senate Review panel is described within the document and a panel of appropriate clinical and non-clinical experts were convened from within the West Midlands.

The panel agree that the remodelling and redesign of the whole health and social care economy should be commended and the approach taken reflects the scale of changes proposed and the challenges faced. However, the Clinical Senate Review Panel also recognises clinical and financial risks which will require further exploration and clarification before the NHS England stage 2 review. There are also some risks from interdependencies outside of the terms of reference of the review, and therefore beyond the remit of the Senate review panel. These risks are all clearly defined within the report, alongside some key recommendations for consideration by the Future Fit Programme.

The Clinical Senate Review panel noted that this report is a NHS England Stage 1 Phase 1 report and further panel will be convened to assess Future Fit programme progress, in January and February 2015.

3. Background

Health services within Shropshire, Telford and Wrekin have developed over many years in order to meet the needs and expectations of the populations served, including that of mid-Wales. With the changing needs of the population, advancements in medicine and the economic environment within which the NHS has to work, however, it is clear that the time has come to look again at the design of services to meet the needs of Shropshire, Telford and Wrekin's dispersed rural and urban populations in order to provide excellent healthcare services for the future.

The "Future Fit" programme (FFP) was commissioned in response to NHS England's 'Call to Action' survey undertaken in November 2013. Leading clinicians and patient representatives met to establish a compelling case for change based around the needs of an increasingly ageing population, the rise in prevalence of long-term conditions, higher public expectations both of the quality and convenience of services and growing workforce pressures; all within an environment of economic challenge across all sectors. The scope of FFP is to design and configure acute and community hospital services. Three hundred clinicians and patients involved in the clinical design work stream agreed that high quality, safe, efficient and sustainable hospital services can only be delivered if the whole of the health and social care economy is functioning to the same high standards. This can only be achieved through whole system transformational change.

The FFP described a clinical model based on three areas of care:

- acute and episodic illness
- the management of long-term conditions and frailty
- the delivery of planned care

The clinical model for acute and episodic care describes an urgent care network, with one central emergency centre working closely with peripheral urgent care centres. For planned care, one central diagnostics and treatment centre will provide circa 80% of planned surgery, whilst the majority of assessment, diagnosis and follow up will be performed closer to peoples' homes. The care of people with long-term conditions will be seamless, responsive and lifelong.

The structural changes proposed describe the consolidation of specialist services to achieve 'critical mass', whilst also addressing the need to improve quality and patient experience through delivering more care closer to home.

Three additional challenges have been identified beyond the reconfiguration of hospital services: the need to integrate health and social care and resolve the funding anomalies between them; the requirement to create community capacity to manage the shift in care closer to home; and, most importantly, the need for local communities and society as a whole to tackle the prevention and wellbeing agenda.

4. Scope and Limitations of the Review

The scope of the review was agreed between Shropshire CCG, Telford and Wrekin CCG and the West Midlands Clinical Senate. The stage 1 review was necessarily limited by the early phase of the FFP, and a range of untested, underpinning hypotheses. Some of the assumptions upon which the proposal was based are novel and the causal relationships asserted are not established through published studies or experience of successful reconfigurations and service/pathway modernisations. Finally, all of the conclusions are limited to the evidence presented, and are not exhaustive.

5. Methodology of Review

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

5.1 Terms of Reference

An approach was made in April 2014 by Shropshire CCG and Telford & Wrekin CCG to the West Midlands Clinical Senate, requesting that a group of external clinicians be convened to challenge and review the work undertaken by the FFP to date, with the aim of:

"Providing informal advisory and expert 'critical' challenge to the service models being developed in the Future Fit: Shaping Healthcare Together programme, as part of NHS England's stage 1 assurance process." (See Appendix 1)

NB It was anticipated at that point that a formal NHS England stage 2 clinical assurance review would be likely to be required to be undertaken in June 2015, once a preferred option had been identified.

The Shropshire CCG and Telford & Wrekin CCG request emphasised the importance of continuity between the clinicians who are involved at key points in the process, as the planning develops through to the formal assessment of the final short-listed options or preferred option which would ultimately go out to public consultation. The West Midlands Clinical Senate, however, took the view that the clinicians required to undertake the formal assessment at stage 2 should be different from those having provided informal advice and challenge at stage 1, in line with NHS England guidance (Clinical Senate Review Process: Guidance Notes 2014).

The Shropshire, Telford and Wrekin "Future Fit" programme was formally adopted onto the West Midlands Clinical Senate work programme by the Clinical Senate Council on the 9th July 2014.

5.2 Process

The process to formulate the clinical advice was led by Simon Brake and Peter Thompson, both of whom are members of the Clinical Senate Council. The Terms of Reference for the work were developed as per NHS England guidance (see Appendix 1). This included the approach for formulating advice and the overall process through which the advice and recommendations would be developed and reported.

The Terms of Reference (ToR) were then shared and agreed with Shropshire CCG, Telford & Wrekin CCG, the “Future Fit” Programme Director and Programme Board. This ensured that the advice which the Clinical Senate had been asked to provide, and the approach to formulating it, were transparent to all key stakeholders. Any comments and feedback received with regard to the ToR were considered and addressed, as appropriate.

The Clinical Senate formulated its advice between October and November 2014. An Independent Clinical Review Team (ICRT) was established to assist the Senate. These included members from professional groups with specific knowledge and expertise in the areas which the Clinical Senate had been asked to provide advice (see Table 1 and Appendix 2). A Confidentiality Agreement was signed and any potential conflicts of interest were identified and declared at the outset of the process. These are recorded in Appendix 3.

Review dates were held on 3rd and 13th October 2014. The ICRT reviewed relevant documentation which had been provided by Shropshire CCG and Telford & Wrekin CCG. Presentations relevant to the review were also made by key members of the FFP (see Appendices 4 and 5).

This report sets out the key issues that were discussed and the emerging 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 the Clinical Senate Review Process: Guidance Notes (NHS England 2014) stage 1 assurance.

5.3 Table 1 Independent Clinical Review Team

The members of the Independent Clinical Review Team (ICRT) were as presented in Table 1 below:

Member	Position	Organisation
Mr Simon Brake	Chair – Shropshire and Telford ICRT	Coventry City Council
Mr Peter Thompson	Vice Chair - Shropshire and Telford ICRT	Birmingham Women's Hospital
Dr Neil Gittoes	Consultant Endocrinologist / Associate Medical Director	University Hospitals Birmingham
Mr Doug Robertson	Consultant Physician	Sandwell and West Birmingham Hospitals NHS Trust
Mr Paresh Sonsale	Consultant T&O	Heart of England NHS Trust
Mr Rajan Paw	Emergency Consultant	The Dudley Group of Hospitals
Ms Liza Walsh	Deputy Director of Nursing	Birmingham Community NHS Trust
Mr Alan Lotinga	Service Director	Birmingham City Council
Ms Deb Smith	Patient Representative	On behalf of West Midlands SCN and Senate NHS England
Mr Robin Comley	Patient Representative	On behalf of West Midlands SCN and Senate NHS England
Dr Mary Montgomery	Clinical Lead	West Midlands SCN and Senate NHS England
Dr Michael Kuo	Consultant in Paediatric Otolaryngology	Birmingham Children's Hospital
Dr Sue Protheroe	Paediatric Gastroenterologist	Birmingham Children's Hospital
Angela Knight Jackson (in attendance)	Clinical Senate Manager	West Midlands SCN and Senate NHS England
Ms Marilyn McKoy (in attendance)	Quality Improvement Lead	West Midlands SCN and Senate NHS England
Karen Edwards (in attendance)	Senate PA	West Midlands SCN and Senate NHS England
Alison Lake (in attendance)	SCN and Senate Admin Support	West Midlands SCN and Senate NHS England

6. Description of Current Service Model

The Shropshire area is served by two Clinical Commissioning Groups (CCGs). Shropshire CCG is based in Shrewsbury and represents 44 GP practices. This CCG serves a population of 302,000 and has coterminous boundaries with Shropshire Council. Telford & Wrekin CCG is based in Telford. This CCG represents 22 GP practices, serves a population of approximately 172, 000 and has coterminous boundaries with Telford Borough Council.

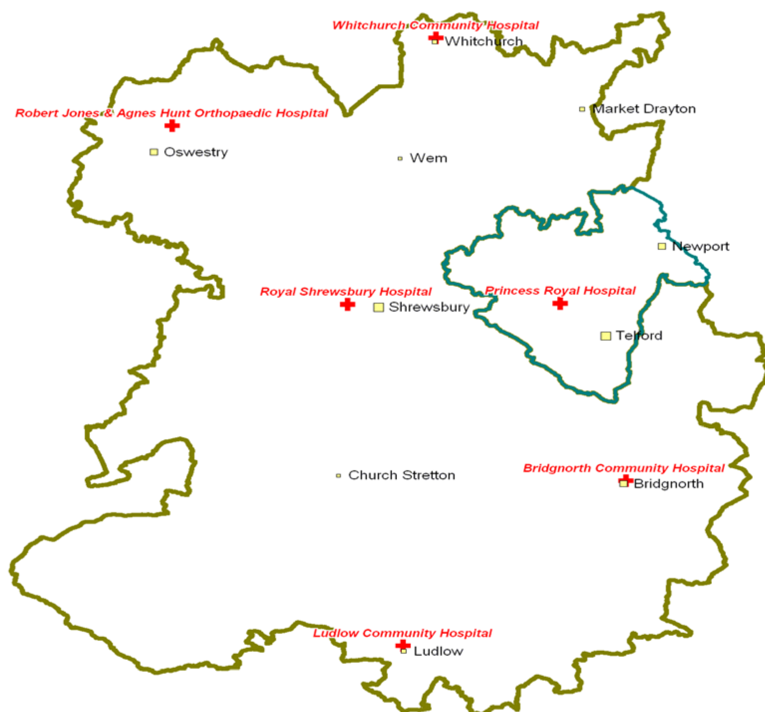
Together the CCGs are responsible for commissioning services in the following areas of care:

- hospital care
- rehabilitation care (such as visits from district nurses)
- urgent and emergency care (including the out-of-hours GP service, ambulance call-outs and A&E)
- community health services
- mental health and learning disability services.

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is the main provider of district general hospital services for half a million people living in Shropshire, Telford & Wrekin and Mid Wales.
Services are delivered from two main acute sites: Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. Both hospitals provide a wide range of acute hospital services, with a combined capacity of 819 beds. The Shrewsbury and Telford Hospital NHS Trust provides outreach services to Shropshire's four Community Hospitals along with the Community Hospital in Welshpool as well as outreach services to Robert Jones & Agnes Hunt Orthopaedic Hospital in Oswestry. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a leading orthopaedic centre of excellence, providing a comprehensive range of musculoskeletal surgical, medical and rehabilitation services both locally, regionally and nationally. The organisation is a single site hospital based in Oswestry, Shropshire, close to the border with Wales and serves both England and Wales, acting as a national healthcare provider.

Shropshire Community Health NHS Trust provides community health services to people across Shropshire, Telford and Wrekin. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, and support to patients with diabetes, respiratory conditions and other long-term health problems. In addition, they provide a range of children's services, including specialist child and adolescent mental health services.
Shropshire's four Community Hospitals have a total of 113 beds. These hospitals, operated by Shropshire Community Health Trust, are situated in Bishops Castle, Bridgnorth, Ludlow and Whitchurch (see figure 1). They provide care for those who do not need acute hospital care or have been transferred from an acute hospital for rehabilitation or recovery following an operation or who need palliative care (Future Fit Programme Execution Plan, 2013).

Figure 1 Map



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6.1 The Current Service Model – Challenges

The spread of services across multiple sites means that services are struggling to avoid fragmentation and incurring additional costs from duplication of services thereby adding to pressures in funding. The clinical and financial sustainability of acute hospital services have been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two main sites is becoming difficult to maintain without compromising the quality and safety of the service.

SaTH currently runs two full accident and emergency (A&E) departments, but does not have a consultant-delivered service available 16 hours a day, over 7 days a week on either of these sites. Even without achieving Royal College standards, the Trust currently has particular medical workforce recruitment issues in respect of: A&E services, stroke, critical care and anaesthetic cover. Most of the services are delivered on two sites, though stroke services have recently been brought together on an interim basis; this latter move having delivered measurable improvements in clinical outcomes. During the stage 1 review, the ICRT were informed that Women's and Children's services had also been consolidated onto a single site in Telford, though it was too early to measure any change in clinical outcomes arising from this.

7. The Case for Change

The commissioners provided and presented information to support the case for change, from which the panel formed the following observations and views:

7.1 Case for Change - Unsustainable Health Model

The ICRT was presented with evidence showing that there is an unsustainable health model across the wider Shropshire, Telford and Wrekin health and social care economy; which therefore warrants a need for fundamental change and improvement.

The panel was of the opinion that the *status quo* is no longer acceptable, and that the requirements to achieve both clinical and financial sustainability were the primary catalysts for change. The panel was presented with evidence regarding the FFP (Clinical Design Workstream Final Report May 2014, Future Fit Programme Execution Plan, and Clinical Services Strategy) but were not provided with evidence that other relevant models had been fully explored. The panel was of the opinion that the proposed FFP model would be advantageous for the majority of the population, whilst a smaller proportion of the population might be disadvantaged; therefore on balance this would represent an overall improvement over the existing service configuration.

The panel acknowledged that the Future Fit Programme Execution Plan (2013) provides the opportunity for:

- Better clinical outcomes (including reduced morbidity and mortality) through bringing specialists together and treating a higher volume of cases routinely so as to maintain and improve skills; as well as by ensuring a greater degree of consultant-delivered clinical decision-making across more hours of the day and more days of the week
- A pattern of services that better meets the population needs; delivers quality comparable with the best anywhere in the NHS through the development of resilient clinical teams; and can become highly attractive to the best workforce, thereby rebuilding staff morale
- Better communication between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care provision both in the community and the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere, with hospitals providing to the highest standards those services which only they can provide (i.e. providing higher dependency and technological care)
- A coordinated and integrated model of care, both across the NHS and across other sectors such as social care and the voluntary sector; with reduced duplication as well as placing the patient at the centre of care.

The panel obtained evidence from the clinical commissioners, other local clinicians and many members of the public who had responded to the “Call to Action” consultation; and accepted that there is a case for making significant change to the pattern of services currently delivered - provided there was no predetermination of where or how the services will be delivered and that there was full pubic and patient engagement in thinking through the options.

The panel was of the view that Future Fit Programme provides the opportunity to improve the quality of care provided to Shropshire, Telford and Wrekin’s changing population.

7.2 The Case for Change – alignment with local, regional and national strategic intentions

The panel was of the view that a clear case for change had been made, based on the evidence presented to it on current performance. The panel noted these were in line with some of the national and local drivers affecting health care systems, in particular:

National Drivers

These include:

- Department of Health (2010) Improving the health and well-being of people with long term conditions: world class services for people with long term conditions
- HM Government (2010) Healthy lives, healthy people: our strategy for public health in England
- Health and Social Care Information Centre (2013a) National Child Measurement Programme: England, 2012/13 school year. Public Health England
- Health and Social Care Information Centre (2013b) Statistics on Smoking.
- Health and Social Care Information Centre (2013c) Statistics on Women's Smoking Status at Time of Delivery
- The Marmot Review (2010) Fair Society Health Lives, The Marmot Review
- National Audit Office (2013) Emergency admissions to hospital: managing the demand, National Audit Office
- National Audit Office (2011) Transforming NHS ambulance services.
- NHS England (2014) Better Care Fund- Revised Planning Guidance
- Monitor (2014) Guidance: Enabling integrated care in the NHS

- NHS England (2013) Transforming urgent and emergency care services in England, Urgent and Emergency Care Review, End of Phase 1 Report.

- NHS England (2013) Transforming urgent and emergency care services in England, Urgent and Emergency Care Review, End of Phase 1 Report, Appendix 1 – Revised Evidence Base from the Urgent and Emergency Care Review.

- NHS England (2013) Statement on the health and social care: Integration Transformation Fund (2013)

- NHS Future Forum (2011) The NHS' role in the public's health

- National Information Board (2014) Personalised Health and Care 2020 Using Data and Technology to Transform Outcomes for Patients and Citizens A Framework for Action.

(See Section 9 for full references)

Local Drivers

These include:

- Announcement of New Shropshire Women and Children's centre in Telford 2014

- Future Fit (2014) Clinical Design – Request for support to West Midlands Clinical Senate July 2014

- Future Fit (2014) Clinical Design Work Stream Final Report, Models of Care May 2014

- Future Fit Clinical Design Work Stream Appendix

- Future Fit Programme Execution Plan v1.4

- Future Fit (2013) Clinical Services Strategy – Shropshire Hospitals Strategic Context v11

(See Section 9 for full references)

8. Clinical Advice and Recommendations

The Commissioners provided and presented documentary and verbal information to the panel. From this information the panel formed the following observations and views:

8.1 Challenges

The panel recognised the challenges of providing healthcare for a mix of both urban and rural populations, such as across Shropshire, Telford and Wrekin where there are two highly-populated areas and a dispersed rural population across a large geographical area.

NB Although the current services provided within the FFP area include the sizeable population of Powys within Wales, the remit of this review is limited to exploring those services provided to the populations served by the two CCGs as part of the NHS in England. Notwithstanding this, however, the ICRT acknowledged that care for the Welsh catchment population served by SaTH and SCH is important and must be properly attended to by the FFP, in discussion with Powys Local Health Board.

The panel acknowledge that national, regional and local political views will play a fundamental role in this review, and identified that inconsistent views expressed by local political bodies may risk undermining any future proposals. The panel, however, did not allow constraints of existing policy, financial requirements or political considerations to limit its response to the FFP; although the consequences of change on surrounding health economies were not taken directly into account by this review.

The panel noted that the FFP is effectively a remodelling and redesign of the whole health and social care economy, which should be commended for its ambition. The innovative and intellectually-demanding approach taken was acknowledged, and reflects the scale of changes proposed - and challenges faced.

8.2 Diagnostic and Treatment Centre

The model of separating DTCs (Diagnostic and Treatment Centres) from acute clinical environments is well established, tested and evidence-based. The panel was of the view that the separation of DTCs from acute providers does reduce the bed-base flexibility of acute medicine to cope with excessive demand, however, and this factor will need to be considered within the risk analysis for stage 2. This should also be informed by the West Midlands Ambulance Service (WMAS) data relating to travel times, patient location and efficient use of ambulance resources.

The panel suggested that the location of the DTC will need to be considered in relation to population concentrations, implication of travel time, choice, accessibility and clinical risk as well as access to acute clinical services from the DTC.

8.3 Emergency Centres vs Urgent Care Centres

The panel was of the view that the model of emergency centres (EC) and urgent care centres (UCC) is both a good idea and are in line with national guidance. The success of the UCCs will be dependent upon ensuring a consistent and equitable service provision for all users regardless of where they live (or whether the UCC is co–located with the EC).

As part of the stage 2 review, there will be a need to further understand the travel and clinical activity modelling, which the panel was informed would be available by January 2015. This will help inform the final decision regarding the number and location of UCCs. The panel recognised the risk expressed by the FFP team regarding separating the EC from public access, and agreed that co-locating a UCC with the EC may resolve some of these issues.

NB The panel did not consider how this model applies to or affects Welsh residents; which should be considered by the FFP.

8.4 Integrated Electronic Patient Record

There are multiple benefits from having an Electronic Patient Record (EPR) and the government is committed to this objective becoming a reality, with the aim that patients will be able to access their own health records by 2018. Although progress is being made throughout health care economies with regards to this objective, to date, none has achieved an integrated primary and secondary care record. The panel noted that the success of the FFP will depend to a large extent upon the success of these Information Technology programmes, in particular the combination of a health and social care record; albeit recognising this may be particularly challenging. The panel was of the view that for EPR to be achieved effectively, both financial investment and pragmatic decisions will need to be made by both commissioners and providers.

8.5 Workforce

The panel recognised that the local health economy across Shropshire, Telford and Wrekin is unsustainable without a transformation in the way in which services are delivered. This provides particular workforce challenges, since the success of any reconfiguration is dependent on an appropriately skilled and sized workforce for the longer-term; with implications for workforce planning, training and education. The panel noted however that the challenges facing this proposed reconfiguration are not significantly different from those faced elsewhere, and therefore learning from neighbouring health and social care economies will be invaluable.

The FFP's clinical design report describes changes in working practice as a key system principle, stating that 90% of both the challenges and the changes proposed sit within working practices. The commissioners have advocated that it is only through changes in working practices that there will be a sensible configuration of buildings and facilities, not the other way around.

The panel acknowledged the difficulties faced by the FFP when trying to meet the challenge of engagement and communications, particularly when public interest and publicity often defaults to questions of how many A&Es there will be in the area and what buildings are going to be built, etc.

The panel was of the view that there are a series of workforce assumptions inherent in the FFP, including with regard to job roles, future career trajectories, training, supervision, sustainability and succession planning for clinicians, Advanced Nurse Practitioners (ANPs) and Allied Health Professionals (AHPs), which needs to be further clarified and tested. The panel felt therefore that it was not possible to express an opinion over the reasonableness of the workforce plans within FFP at this stage.

The rationale for the FFP not having a Consultant-delivered service, but rather a Consultant-led service, was understood and accepted. The panel suggested however that the rationale for this should be made clear to all stakeholders, including patients.

The panel was of the view that there is a need to support clinicians in behaving differently and delivering change through new working practices. Individual clinicians will need to understand and accept proposed new models of working – which, if deemed unacceptable, may result in further destabilisation of the workforce. GPs may also need to be ‘up-skilled’ or supported in some specialist areas e.g. paediatrics, especially in more rural areas. These changes in working practices are also on the back of those changes required to achieve ‘Seven Day Services’, with equitable outcomes for patients achieved across the full week. Whilst the panel agreed that it is likely that the present workforce configuration is unsustainable, this would again need to be clearly evidenced.

8.6 Public Health Improvement and Integration

The panel noted the forward-thinking public health agenda within FFP, where activity and impact is required from specialisms, through generalisms (i.e. primary care), back into community mobilisation, community resilience and individual well-being. The FFP wishes to mobilise enthusiasm for change at all levels, with a focus on delivery through local communities (who in turn apply “bottom up” pressure for service change on local authorities, with action being community driven, not statutorily driven, “top down”). This thesis is in line with NHS England’s Five Year Forward View (5YFV) for the NHS (NHS England, November 2014).

The panel were of the view that the proposed reductions in activity through preventative strategies within FFP are ambitious, as reductions of this magnitude have not previously been achieved within the NHS, and it was yet to be evidenced whether this will result in a reduction in clinical need, activity and bed occupancy. The panel therefore urged FPP to keep remodelling the assumptions applied to the

efficacy of public health interventions, using all available evidence to ensure they are realistic, in advance of the NHS England stage 2 review. The panel suggested that this should include broad socio-economic evidence such as that included within the Marmot Review report (2010) and the 5YFV.

8.7 Acute Bed Reduction

The acute activity modelling element of the FFP proposal includes a number of elements, the most significant being the reduction in average occupied bed days to 7 days and introduction of a 7 day financial 'trim point'. The panel recognised the clinical rationale behind this assertion and supported it in principle. The application of this model across all acute activity for Shropshire and Telford however was felt to represent a significant, albeit logical, step which has not previously been delivered successfully at such scale elsewhere in the NHS. The panel's opinion was that the modelling will benefit significantly from further sensitivity analysis around this factor in advance of the stage 2 assurance review, as well as further exploration of the clinical evidence from elsewhere to support this contention.

8.8 Children's Services

The panel were informed that the women's and children's services had recently been consolidated onto the Telford site. There is though still a paediatric assessment unit which is open 12 hours a day in Shrewsbury. With this new development, the panel was concerned that the FFP considers whether:

a) this creates a fixed point in the new plans, which is contrary to the espoused FPP clinical design principle that there are no fixed points (i.e. are these services to remain in Telford in the long term?); and if
b) it is necessary for women's and children's services to be co-located with support services such as an emergency centre and critical care facilities.

The rationale for the relocation of the women and children's service was not clear to the panel. The review of this service appears to have been undertaken separately, and the approach to the development of the Shrewsbury paediatric service (PAU) seems inconsistent with the FFP programme. In particular, the model focusses on acute care and has not considered education, community care or primary care, etc.; and will need to do so in the future. The panel felt that this service area needed more joined-up thinking, as conceptually there is evidence in favour of basing services around children and families, with a focus on improvement across antenatal, postnatal and early years (<2yrs) care.

The panel, however, acknowledged the FFP ethos that change is emergent and there is a five - seven year lead-in time to new services and related infrastructure

being developed; and as such recognised that there is a need to maintain continuity in the existing configuration which may at times seem at odds with future plans.

8.9 Clinical and Public Engagement

The panel received evidence that the FFP had engaged with clinicians and residents at an early stage in its development, with 300 persons (approximately 50 patients and 250 clinicians) being involved. In addition, a smaller number of individuals have been involved in focus groups looking at specific issues. To date, people have generally supported the FFP's medium and long-term proposals which have been put forward.

The panel was of the view that engagement has been both inclusive and supportive. This demonstrates commendable practice which can be used as a model elsewhere. Going forward, the FFP team will need to continue to comply with the NHS England's guidance with regard to public engagement in respect of proposals for service change.

8.10 Risk

The panel was presented by the FFP with the dilemmas of managing risk within transformational, often radical, change. FFP identified that there is currently no existing forum to manage whole- system risk i.e across Telford, Shropshire and Powys. The Health and Wellbeing Boards are not currently constructed to undertake this role and neither are the individual commissioning organisations, whether local authorities or CCGs, equipped to carry this level of cross-system risk. The panel was informed by the FFP, however, that it believed it could undertake whole-system change without there being a forum to carry whole-system risk.

The panel was of the opinion that as a high-level proposal, the FFP provides a potential way forward to enable the construction of a clinically and financially-sustainable health and social care economy. The panel had concerns, however, regarding the level of potential clinical and financial risk; and was clear that a significant level of detail would now need to be worked up in order to prove the model could be clinically and financially sustainable. The panel suggested that certain areas of the proposal could be implemented early on in order to prove its overall viability - e.g. the integration of records, reduction of levels smoking etc. This would then provide an early indication of the likely future success of the programme as a whole, which would also help its further assurance through stage 2. The panel was also in agreement that a back-up proposal should be developed, should the current proposal not prove to be achievable once more fully worked-up.

The panel was of the view that there are several modelling assumptions which either assert novel causal relationships or else are significantly in excess of previously achieved outcomes. Work, therefore, needs to start as early as possible to model the impact of these assumptions, using sensitivity analysis, on the various components of the plans; as well as to review their impact on implementation, refreshing the assumptions of the final model based on these early findings. If the modelling

assumptions are proven to be incorrect, there is the risk to the health economy of suffering signification pressure (e.g. if the presenting clinical need exceeds the reduced bed availability). A graduated approach to implementation should therefore be considered in order to mitigate this risk. Furthermore, consideration of early bed reductions in anticipation of the future configuration might be more likely to achieve a sustainable change.

The panel noted that responsibility for assuring implementation of certain elements of FFP sits outside NHS England (e.g. local government). This may therefore pose obstacles to the FFP as well as presenting a greater risk to delivery.

The panel was also of the view that further exploration of risk in respect of detailed modelling assumptions as well as national guidance (Clinical Senate Review Process: Guidance Notes 2014) will need to be undertaken prior to the stage 2 assurance process.

9. References

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10. Abbreviations and Glossary of Terms

AHP- Allied Health Professional
An umbrella term encompassing a group of professionals such as therapists , chiropodists, podiatrists, dieticians, occupational therapists, , paramedics, physiotherapists, radiographers and speech and language therapists.

ANPs – Advanced Nurse Practitioners
A registered nurse who has usually undergone further accredited education and training at an academic level.

CCG - Clinical Commissioning Group
An organisation responsible for the commissioning of healthcare services in their geographical area.

CRG – Clinical Reference Group

CRGs are responsible for providing the NHS with clinical advice regarding specialised services, and for promoting equity of access to high quality services for all patients, regardless of where they live.

CS – Clinical Senate

Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent

DTC - Diagnostic and Treatment Centre
A place that offers diagnostic services to the medical profession or general public

EC - Emergency Care
Conditions that are serious or life threatening emergency needs

FFP - Future Fit Programme
The Future Fit programme is a case for change which proposes to design and configure acute and community hospital services fit for the next twenty years

EPR System - Electronic Patient Record system
An IT system allowing the creation and access of patient's medical records

ICRT – Independent Clinical Review Team

Assess the strength of the evidence base of the case for change and proposed models

IT – Information Technology

M&M - Mortality and Morbidity Rates
The incidence of Mortality (Death) and Morbidity (poor health)

NICE – National Institute for Clinical Excellence

National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in the United Kingdom

NHS England – National Health Service England

NHS England authorises the clinical commissioning groups, which are the drivers of the clinically-led commissioning system introduced by the Health and Social Care Act.

ODN – Operational Delivery Network

ODNs ensure the delivery of safe and effective services across the patient pathway and help secure the best outcome for patients

PEP – Programme Execution Plan

Programme Execution Plan (PEP) forms the basis for the development of an agreed model of care for excellent and sustainable acute and community hospitals that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin and Mid Wales

PH - Public Health
Local and National organisation with the responsibility for the protection and improvement of the nation's health and wellbeing, and reduction of health inequalities.

PRH – Princess Royal Hospital

RJAH – Robert Jones Agnes Hunt Hospital

RSH – Royal Shrewsbury Hospital

S&TH – Shrewsbury and Telford Hospital NHS Trust

T&O – Trauma and Orthopaedics

Trauma and orthopaedics deals primarily with injuries, congenital and acquired disorders of the bones, and joints and their associated soft tissues, including ligaments, nerves and muscles.

TOR – Terms of Reference

The purpose and structure of a project, committee, meeting, or any similar collection of people who have agreed to work together to accomplish a shared goal

UC - Urgent Care
Conditions that is urgent but non-life threatening

UCC's- Urgent Care Centres
Centres that effectively deliver care to patient with conditions that are urgent but non-life threatening

WMAS – West Midlands Ambulance Service
West Midlands Ambulance Service NHS Foundation Trust provides a range of services such as NHS 111, emergency and non-emergency healthcare and transport across the West Midlands region

WMSCN – West Midlands Strategic Clinical Network

Strategic Clinical Networks bring together those who use the service, provide and commission the service to make improvements in outcomes for complex patient pathways using an integrated, whole system approach

PAU - Paediatric Assessment Unit
Paediatric assessment unit based at Royal Shrewsbury Hospital. This provides a part of the range of care for children delivered by The Shrewsbury and Telford Hospital NHS children at their two hospitals.

NHS England

11. Appendices

Appendix 1 – Terms of Reference

West Midlands Clinical Senate
Future Fit Programme
1st Stage Assurance

Terms of Reference

West Midlands Clinical Senate

'Future Fit' programme Terms of Reference

First published: September 2014

Amended: October 2014

Prepared by

Angela Knight Jackson
Clinical Senate Manager

Marilyn McKoy
Quality Improvement Lead

TERMS OF REFERENCE

Terms of Reference for: Clinical Review Panel

Topic: 'Future Fit programme'

Sponsoring Organisations: Shropshire CCG and Telford & Wrekin CCG

Clinical Senate: West Midlands Clinical Senate

NHS England (regional or area team): Shropshire and Staffordshire NHSE Area Team

Terms of Reference agreed by:

Name DR DAVID HEGARTY **on behalf of the Clinical Senate**

Date: 09.10.14

Name DR BILL GOWANS **on behalf of the Sponsoring Organisations**

Date: 13.10.14

1. Independent Clinical Review Team Members

Chair:

Name	Position	Organisation
Mr Simon Brake	Assistant Director – Communities and Health	Coventry City Council

Vice Chair:

Name	**Position**	**Organisation**
Mr Peter Thompson	Consultant Obstetrician and Medical Director	Birmingham Women's NHS Foundation Trust

Members:

Name	**Position**	**Organisation**
Nathan Hudson	General Manager	West Midlands Ambulance Service
Mark Farthing	Head of Clinical Practice Long Term Conditions	West Midlands Ambulance Service
Neil Gittoes	Consultant Endocrinologist and Associate Medical Director	University Hospitals Birmingham NHS Foundation Trust
Doug Robertson	Consultant Physician	Sandwell and West Birmingham Hospital NHS Trust
Paresh Sonsale	Consultant in Trauma and Orthopaedic s	Heart of England NHS Trust
Rajan Paw	Consultant in Emergency Physician	The Dudley Group NHS Foundation Trust
Alan Lotinga	Service Director – Health and Wellbeing	Birmingham City Council
Deb Smith Robin Comley	Patient and Public Representatives (x2)	On behalf of the West Midlands SCN and Senate, NHS England
Mary Montgomery	Clinical Lead for Maternity	West Midlands SCN and Senate NHS England
Michael Kuo	Consultant Paediatric	Birmingham Children's

	Otolaryngologist	Hospital NHS Trust
Sue Protheroe	Paediatric Gastroenterologist	Birmingham Children's Hospital NHS Trust
Liza Walsh	Associate Director of Nursing	Birmingham Community Healthcare NHS Trust
In attendance		
Angela Knight Jackson	Clinical Senate Manager	West Midlands SCN and Senate NHS England
Marilyn McKoy	Quality Improvement Lead	West Midlands SCN and Senate NHS England
Karen Edwards	Senate PA	West Midlands SCN and Senate NHS England
Alison Lake	Admin Support	West Midlands SCN and Senate NHS England

All independent 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 Stage 1 report.

2. Aims and Objectives of the Independent Clinical Review

2.1 Aim

To provide informal advisory and expert 'critical' challenge, to the service models being developed in the Future Fit: Shaping Healthcare Together programme as part of NHS England's stage 1 assurance process.

2.2 Objectives

The Independent Clinical Review Team will:

- Assess the strength of the clinical case for change
- Check alignment with clinical guidelines and best practice
- Ensure an appropriate range of clinical models have been explored and that potential risks are identified and mitigated
- Assess alignment between the proposed change and strategic commissioning intentions
- Identify key areas where there is no need to repeat work which has been undertaken, ensure and impartial input to the Board and meet the formal requirements within the framework to which the Clinical Senate must adhere
- Provide a report of the advice generated from the clinical review panel
- Complete the NHS England assurance Stage 1

3. Timeline

Week Beginning	Action	Organisation

Overall timeline July 14 – March 2015	**Phase 1** -Critical Friend Challenge and review vision and models Challenge and review options	ICRT
15th September	Agree terms of reference Request for documentation from the sponsoring organisation Conflict of Interest and confidentiality guidance to the Independent Clinical Review Team	Shropshire CCG CS (Clinical Senate) CS
22nd September	Clinical Senate receives documentation	Shropshire CCG
22nd September	Documents and Clinical Senate process, governance and guidance dispatched to the independent clinical review team	CS
22nd-29th September	Independent Clinical Review Team reading	CS
29th-September	Independent Clinical Review Team Meeting	CS
13th October	Independent Clinical Review Team Meeting	CS
27th October	Independent Clinical Review Team – report writing	CS
3rd November	Draft report to sponsoring organisation for fact checking	CS
12th November	Report to Clinical Senate Council	CS
19th November	Clinical Senate Council meeting - for formal endorsement of advice	
1st December 2014	Submit final report to sponsoring organisation Publish and disseminate as per terms of reference	CS
May 2015	**Phase 2**- Formal Stage 2 Review	Shropshire CCG CS NHS England

4. Methodology

The role of the independent clinical review team will be to examine documentary evidence, carry out site visits if necessary and decide recommendations.

It is anticipated that the review will be over 2 days and will take place on the following dates:

3rd October 2014
13th October 2014

The independent 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.
Alignment with other national, regional and local intentions?
Is there evidence of clinical overstatement or optimism bias in the proposals?
The interdependencies involved in the clinical design work:
Acute and episodic; Long term conditions / Frail Elderly and Planned care
Cross cutting themes identified by the Sponsoring Organisation:
-Mental health
-Women's and children's
-Social care
-Primary care
-Secondary care
-IT
-Therapeutics
-Ambulance and transport
-Diagnostics
-Workforce/7 Day working
-Cancer
-Therapies

5. Reporting

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

The Independent Clinical Review Team will submit a draft report proportionate to a stage 1 review 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 agreement following phase 1 of the review and the clinical advice will be considered as part of the NHS England's Staffordshire and Shropshire Area Team Stage 1 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

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 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 independent clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

8. Accountability and Governance

The independent 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 Organisations

The Sponsoring Organisations 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 Stage 1 formal service change assurance process.

9.2 The Clinical Senate Council and the Sponsoring Organisations

The Clinical Senate Council and the Sponsoring Organisations 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 The Independent Clinical Review Team

The Independent Clinical Review Team will:

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template proportionate to stage 1 review process and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
- keep accurate notes of meetings.

9.4 The Independent Clinical Review Team Members

The Independent Clinical Review Team members will undertake to:

- commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

10. Appendices

Appendix 1 (within ToR)

Declaration of Conflict of Interest

West Midlands Clinical Senate Future Fit Programme

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

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

Name:

Position:

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

For completion

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

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

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

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

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

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

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

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

Other – please specify

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

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

Signature:

Name:

Date:

Appendix 2 (within ToR)

Confidentiality Agreement

West Midlands Clinical Senate Independent Clinical Review Team Future Fit: Shaping Healthcare Together programme

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 Fit: Shaping Healthcare Together programme

Signed ________________________________ Date: ________________

Name (caps) _____________________________

Appendix 3 (within TOR)

West Midlands Clinical Senate Independent Clinical Review Team Report Template
Future Fit: Shaping Healthcare Together programme

[senate email]@nhs.net

Date of publication to sponsoring organisation:

CHAIR'S FOREWORD (Independent Clinical Review Team)

Statement from Clinical Senate Chair

SUMMARY & KEY RECOMMENDATIONS

BACKGROUND

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
Independent Clinical Review Team Members biographies and any declarations of interest Background-
(NB this should be a summary and is not intended to be the set of evidence or information provided)

Appendix 2 - ICRT Panel Member Biographies

MEMBER BIOGRAPHY / PROFILE

Name	Mr Simon Brake, Chair, Independent Clinical Review Panel
BRIEF INTRODUCTION Simon is a local government senior manager, having worked in health and social care in a variety of roles at local, sub-regional, regional and national levels for the past seventeen years. After graduating from the University of Warwick with a degree in Politics, Simon trained as general manager in the UK National Health Service, and has worked as an operational general manager in several acute hospitals, as a specialist health commissioner on a and national level, and as a civil servant in the national Department of Health. Simon has also completed an MPA (Masters in Public Administration) at the University of Warwick, an ERASMUS year at the Sciences-Po Bordeaux, France, as well as completing post graduate studies in conflict resolution. Working with clinical colleagues, Simon led the transformation of maternity and neonatal services across the West Midlands whilst commissioning specialist services for children, and, since 2006, been working in local government. In his current role, as Assistant Director for Policy, Performance & Health with Coventry City Council, Simon leads on policy and performance for health, social care, libraries, adult education, public safety and housing, supporting elected members to reduce inequalities and improve services for residents of the city, responding to and delivering the significant reductions in funding for local government, scrutinising and overseeing the city's health services, as well as chairing the local Coventry Citizen's Advice Bureau. With a staff of some 800 in his City Council role, and an annual budget of approximately £20 million, Simon is also responsible for leading the City Council's response to the current health reforms, sitting on the board of the city's 2 CCG clinical leadership teams, and representing the Authority within the new sub regional system board, as well as leading and operationally managing the city's library, translation, resilience & emergency planning and adult education services.	

MEMBER BIOGRAPHY / PROFILE

Name	Mr Peter Thompson Vice-Chair, Independent Clinical Review Panel
BRIEF INTRODUCTION I am a Consultant Obstetrician and the Medical Director at Birmingham Women's NHS Foundation Trust, an acute specialist Trust providing maternity, neonatal, genetics, gynaecology and support services. I have been a consultant in Birmingham for 13 years and I am presently the West Midlands Senate representative on the CRG for specialist maternity services. In the past I have played a lead role in the Southern West Midlands	

Newborn Service and the West Midlands Children, Young People and Maternity Service Strategy Group, led by the West Midlands Strategic Health authority.

MEMBER BIOGRAPHY / PROFILE

Name	Dr Neil Gittoes Consultant Endocrinologist and Associate Medical Director, University Hospitals Birmingham.
BRIEF INTRODUCTION I graduated with honours from the University of Birmingham in 1990 and have always worked in the West Midlands. I am Consultant Endocrinologist at the Queen Elizabeth Hospital (QEH). My initial career was as a senior clinical academic supported by the MRC and honoured by award of Goulstonian Lecturer by the Royal College of Physicians (RCP). As Divisional Director at QEH (2008-2011), I had responsibility for acute services, including A&E, unselected medicine and neurosciences. Since 2011, I have been Associate Medical Director for Clinical Partnerships, working closely with clinical commissioning groups. I also sit on the NHS England Commissioning Group for Specialist Endocrinology. Throughout my consultant career, I have held senior positions at a national level working with charities, professional societies and many patient groups. I devised and lead a national peer review of osteoporosis services scheme. I have national roles in medical education, including with the RCP. I have published widely and have an active clinical and laboratory research portfolio.	

MEMBER BIOGRAPHY / PROFILE

Name	Mr Doug Robertson Secondary Care Board Member, North Staffordshire Clinical Commissioning Group and Consultant Physician, Acute Medicine, Diabetes and Endocrinology
BRIEF INTRODUCTION I have been a consultant physician clinically active in long term conditions (diabetes & hypertension) and urgent care, for 20 years. I have had substantial experience over time chairing Trust committees: clinical governance, research ethics, and risk. I am trained and lead on incident investigation, and am experienced in complaint resolution and learning. With 10 years experience as Clinical and Divisional Director in Medicine and Emergency Care, I contribute to NHS England's Urgent Care and 7-day working workshops and recently led multi-professional groups across the Health Economy for clinical pathway development and Ambulatory Emergency Care, the latter receiving an award for stakeholder engagement.	

I take part in multicentre cardiovascular outcome trials, and am trained in, and teach, critical appraisal methodology. Associate Clinical Professor at Warwick Medical School, and on the Royal College of Physicians' Education Faculty, delivering training in leadership, education methods and patient safety, I sit on the Acute Medicine and General Internal Medicine Training Committees in the West Midlands, on the WMQRS Clinical Reference Group and the West Midlands Diabetes Network. I have chaired multi-professional and patient engagement groups for our health economy, including the local diabetes network and urgent care models of care. As SHA sponsored Clinical Champion for Prevention I have used this cross-organisational approach to develop a Health Improvement and Social Inclusion programme for the local health economy, and out of this work, am now UK representative on the International Network of Health Promoting Hospitals' General Assembly. Learning all the time as a Secondary Care Board member of North Staffordshire CCG, I aim to be an effective non-executive director: developing a collective view through debate and challenge, and holding to account both the CCG and its providers through Board Committees (Quality & Safety, Clinical Priorities and Audit) and triangulation with visits throughout the health economy.

MEMBER BIOGRAPHY / PROFILE

Name	Mr Paresh Sonsale Orthopaedic Consultant, Clinical Lead – Trauma & Orthopaedics, Good Hope Hospital
BRIEF INTRODUCTION I work as an Orthopaedic Consultant for Heart of England NHS foundation trust which is one of the largest trusts in the UK. I also work as a Clinical Lead for Trauma and Orthopaedics for Good Hope Hospital. As a part of my outreach clinic I work at Sir Robert Peel hospital, Tamworth. Thus I serve a large population of North Birmingham and South Staffordshire I passed my basic qualification, MBBS, in 1989. I have Orthopaedic experience of more than 25 years and have Consultant experience of nearly 10 years. I have passed FRCS orth. in addition to holding other qualifications of M. Ch., Master of Surgery (MS), and Diploma in Orthopaedic surgery. I have special interest in Joint replacement, Arthroscopic surgery of Shoulder and Knee and Hand surgery. I have done a research thesis as part of my reparation for M. Ch and Masters. I have knowledge and experience of nearly 20 years of practice in NHS and I feel I will be able to assist the Commissioners to achieve their goal of providing best quality care to the local population. I will be able to advise and provide clinical leadership to meet challenges in the NHS. I already provide support to Clinicians in my role as Clinical Lead	

and I will be able to translate this to a much bigger scale in the West Midlands. I participate in management of one of the largest trusts in the UK and have an awareness of day to day running and the challenges faced by NHS.

Thus I will be able to champion provision of quality assurance and improvement for the NHS in West Midlands. I see this as an opportunity to improve the local NHS to the highest standards within the limitations of financial constraints faced by the NHS.

MEMBER BIOGRAPHY / PROFILE

Name	Mr Rajan Chimanlal Paw A&E Consultant, The Dudley Group of Hospitals

BRIEF INTRODUCTION

I am a Consultant Emergency Physician and Clinical Director of Urgent care at the Dudley Group NHS Foundation Trust. I have trained and practiced through my whole career in the West Midlands, and along with Emergency Medicine I have worked in General medicine, Anaesthetics and Orthopaedics. I have been involved in emergency service redesign for the last 4 years

I see my role at the clinical senate to provide a external clinical sense check to redevelopment plans. It is easy to be so involved in service redesign that you cannot lift your head up and see the bigger implications or be blind to certain issues as you are intricately involved in the process of redesign. I see my role to provide a external view that can point out issues that may have been overlooked or implications not fully thought out.

MEMBER BIOGRAPHY / PROFILE

Name	Ms Liza Walsh Deputy Director of Nursing, Birmingham Community NHS Trust

BRIEF INTRODUCTION

Biography requested. None received.

MEMBER BIOGRAPHY / PROFILE

Name	Mr Alan Lotinga Service Director, Health and Wellbeing, Birmingham City Council, Directorate for People

BRIEF INTRODUCTION

Worked in Local Government since 1980, with spells in the NHS and consultancy. Qualified as an accountant (CIPFA) in 1985, focused on health and social care since 1990, branching initially from finance and strategic/support services to wider management. Joined Birmingham City Council in 2009 from Staffordshire County Council. Currently Service Director (Health and Wellbeing) in the Directorate for People. Started in Birmingham as what was then called the Director of the Health and Wellbeing Partnership – focusing on a range citywide JSNA work, joint commissioning, health inequalities, and personalisation. My current responsibilities include the leadership and transformation of Adults Social Work, the Continuous Improvement Team, and our Customer Involvement Unit; I lead for the City Council on partnership arrangements with the NHS; and I currently chair the Birmingham Adults Safeguarding Board. My most significant more recent major health and care partnership activities have been establishing the Birmingham Health and Wellbeing Board arrangements and Senior Responsible Officer for the Better Care Fund. I believe the mutual trust and emphasis on transparency I have promoted over the past 5 years, and the importance of integrity in dealings with partners, are paying off. I am a Local Government Association Peer Reviewer and contribute to a number of networks.

MEMBER BIOGRAPHY / PROFILE

Name	Ms Deb Smith Patient Representative
BRIEF INTRODUCTION I am a patient leader from the Worcester and Arden area and also from West Midlands Clinical Senate. I am passionate about good healthcare having been a psychiatric nurse until health problems prevented that and am a strong advocate for mental health issues. I was vice chair of South Warwickshire CCG's work stream for patient involvement and am a shadow Governor for my local Mental Health Trust and a member of my local Acute Trust. I have used mental health services myself and as a long time sufferer of fybromyalgia I have used primary and secondary services for this. I try and put the patient's voice at the heart of all I do.	

MEMBER BIOGRAPHY / PROFILE

Name	Mr Robin Comley Patient Representative
BRIEF INTRODUCTION I am a pensioner and have lived with my wife in Telford for six years. I am a survivor of both bowel and nasal cancer as well as diabetes, so have a lot of experience of the NHS. I currently help run a support group for Head & Neck patients, and serve on a hospital cancer forum as well as the West Midland Cancer Patient Expert Advisory Group. Recently I was asked to join a regional group of cancer doctors and nurses as one of two patient representatives, and have been a member of the Citizens Working Party establishing the Citizens Senate in the West Midlands. Before retirement, I worked as an electronics engineer designing and maintaining computer control systems for the water industry. As a local patient, I am acutely aware that I must obtain the best possible result for the County.	

MEMBER BIOGRAPHY / PROFILE

Name	Dr Mary Montgomery Clinical Lead, West Midlands Strategic Clinical Network
BRIEF INTRODUCTION I joined Birmingham Children's Hospital in 2010 as a Paediatric Intensivist and as Clinical Lead for KIDS – setting up Kids Intensive Care and Decision Support (KIDS) which provides single telephone number access for clinicians in the West Midlands to	

Paediatric Intensive Care (PIC) Consultant advice for critically ill children, PIC beds, trained transport teams, specialised ambulances and equipment, and logistics. The service has streamlined the pathway of care for critically ill children in the region, providing paediatric intensive care 'without walls', from the moment the child presents at the District General Hospital, using telecommunication technology to conference multiple professionals to plan best management. Service developments include all parts of the network: lowering referral thresholds; supporting local care wherever possible; transparent governance; sharing learning through outreach and education; improving customer service; improving family experience of care.

I am Clinical Lead at WMSCN for the development of the West Midlands Paediatric Critical Care ODN, and Networks ACMO at BCH: driving improvements in networked working across patient pathways, including PIC; integrating neonatal and paediatric transport and in utero referrals; general paediatric pathways; paediatric gastroenterology; general paediatric surgery; neonatal surgery – with the focus being increased care closer to home, improved ease of access to (telephone) advice, seamless networked care across pathways between different providers, improving efficiency (more for less…).

I bring my personal qualities as a networker and facilitator, able to see how local issues fit into 'the big picture', leadership qualities, experience and training (NHS Leadership Academy Fellow 2012-2013), human factors and crew resource management knowledge and experience, quality improvement methodology, and my embedded belief that though skills, knowledge and experience are all necessary to provide best patient care, without the 'human' element or 'non-technical skills' we cannot build the culture necessary to truly excel.

MEMBER BIOGRAPHY / PROFILE

Name	Dr Michael Kuo Consultant in Paediatric Otolaryngology, Birmingham Children's Hospital
BRIEF INTRODUCTION Biography required. None received.	

MEMBER BIOGRAPHY / PROFILE

Name	Dr Sue Protheroe Paediatric Gastroenterologist, Birmingham Children's Hospital
BRIEF INTRODUCTION	

Member of NHS-E Clinical Reference Group for paediatrics- speciality medicine. Council member for 6 years (Chair of Education Committee and Convenor) of national Society, (BSPGHAN), representing multi-professional groups and working in partnership with RCPCH, Charitable and Patients organisations and lead of national network for patients with intestinal failure. Quality Advisor for CSAC College Speciality Advisory Committee for training.

Expert Advisory group Chair W Midlands Clinical Senate Assembly. Clinical Lead of Operational Delivery Network for Paediatric Gastroenterology, Hepatology & Nutrition. Clinical departmental lead responsible for governance, quality and productivity improvement.

I can provide knowledge and experience of working in a leadership role at departmental, Trust, regional and national arenas. I am committed to developing collaborative clinical networks and clinically-led commissioning within the NHS. I can work across boundaries to ensure collaborative working between the Clinical Senate, CRG's, NHS-E and social care. I will provide expertise and strategic advice on how health services should be designed in the W. Midlands for all children.

I have developed experience in evidence based decisions and policy –making, having set out Service Specifications and other CRG commissioning products (QIP's, dashboards), network pathways and have advised on quality standards for NICE. I understand the importance and am committed to achieving best value pathways to improving improve patient outcomes and quality.

I have worked in partnership with a range of external organisations working with patients and the public such as charitable bodies (Patients Association, Coeliac UK) and patient groups in our Trust to obtain awareness of issues. I can easily access the consensus opinion of regional and national colleagues via the clinical networks to obtain a collective view to achieve outcomes that are clinically supported and promote the needs of patients above all

Appendix 3- Declaration of Interest

Dr Neil Gittoes, Consultant and Associate Medical Director at UHB, declared that UHB provides specialist care for many clinical areas.

Mr Robin Comley, Patient Representative, declared that he is a patient in the area affected

No other declaration of interest were declared by the ICRT.

Appendix 4 - Day 1 Final Agenda

West Midlands Clinical Senate

DAY 1

Independent Clinical Review Panel
Shropshire and Telford – Future Fit Programme

Friday 3rd October 2014, 10.00 am until 4.30 pm

Venue – The International Convention Centre (The ICC), Broad Street, Birmingham, B1 2EA

PLEASE REPORT TO MAIN BUSINESS RECEPTION IN THE FIRST INSTANCE

AGENDA

Item			Purpose
10.00	1	Arrival with Refreshments and Panel Pre-meet Simon Brake (Chair) Peter Thompson (Vice Chair)	
10.30	2	Declaration of Interest	
10.40	3	Session 1: Introduction and Review of Documentation Submitted	Review ToR Overview of the documentation
12.00		Panel Discussion	Explore and clarify specific issues Formulate questions for Commissioners
12.30	4	Lunch	
1.15	5	Panel Discussion	As Above
1.45	6	Session 2: Presentation of Clinical Case for Change Dr Bill Gowans along with names to be confirmed • Clinical Design • Programme Execution Plan	Commissioners presentation of the Clinical Case for Change and Clinical Design

		• Areas for the Panel to Consider	
3.30	7	Refreshment Break (if required)	
3.40	8	Panel Deliberations and Next Steps	Assess Evidence Presented Formulate agenda for Day 2
4.30	9	End	

NHS England
West Midlands Clinical Senate

Appendix 5 - Day 2 Final Agenda

DAY 2

Independent Clinical Review Panel
Shropshire and Telford – Future Fit Programme

Monday 13th October 2014, 10.00 am until 4.30 pm

Venue – The International Convention Centre (The ICC), Broad Street, Birmingham, B1 2EA

PLEASE REPORT TO MAIN BUSINESS RECEPTION IN THE FIRST INSTANCE

AGENDA

Item			Purpose
10.00	1	Arrival with Refreshments and Panel Pre-meet Simon Brake (Chair) Peter Thompson (Vice Chair)	
10.30	2	Declaration of Interest and Review of Day 1	Review ToR (amended)
10.40	3	Session 1: Introduction and Continuation of Documentation – Bill Gowans (representing commissioning organisation)	Overview of further documentation (available on day only)
12.00		Panel Discussion	Points of clarification
12.30		Lunch	
1.15		Session 2: REPORT WRITING	Compilation of first draft of report
3.30		Refreshment Break (if required)	
3.40		Summary and Conclusions	Discuss next steps in review process
4.30		End	

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