NHS
East of England
Clinical Senate

East Suffolk & North Essex NHS Foundation Trust

Report of the Clinical Senate independent review panel held on 18 September 2019.

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Glossary of abbreviations used in the report

CCG	Clinical Commissioning Group
ESNEFT	East Suffolk & North Essex NHS Foundation Trust
EOCC	(Adult inpatient) elective orthopaedic care centre
GIRFT	'Getting it right first time', a national programme designed to help improve the quality of care within the NHS by bringing efficiencies and improvements
ICS	Suffolk & North Essex Integrated Care System
IT	Information Technology
MSK	Musculoskeletal
PAC	Picture archiving and communication system
PROMs	Patient record outcome measures (questionnaires patients complete on their health and quality of life)
STP	Sustainability and Transformation Partnership
The Trust	East Suffolk & North Essex NHS Foundation Trust
24/7	24 hours a day, seven days a week.

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EXECUTIVE SUMMARY

The East Suffolk and North Essex NHS Foundation Trust (ESNEFT) requested the East of England Clinical Senate to review its proposals to improve patient pathways and develop a single Elective Orthopaedic Care Centre (EOCC).

The review panel agreed that the case for change and proposals were well thought through with a sound evidence base, and that the ESNEFT team had recognised and acknowledged that there was still work to do on the detail.

The panel supported the proposed direction of travel and agreed that the proposals were a step in the right direction. The Trust's aim to reduce non-clinical cancellations for elective orthopaedic surgery was very much supported by the panel. The proposals also aimed to reduce waiting times for patients through enhanced patient pathways with a requirement for fewer patient visits, along with the development of an (adult in-patient) elective orthopaedic centre with protection from emergency inpatient admissions. The Trust already had plans in place to reduce variation across the two sites.

The panel agreed that the larger clinical team should mean greater resilience and the concentration of procedures onto one site and should also provide enhanced training opportunities for all staff.

The panel was of the opinion that it made greater clinical sense and should provide a wider range of benefits to other clinical services at both Colchester and Ipswich Hospitals if the adult inpatient elective orthopaedic care centre (EOCC) was located on the Colchester Hospital estate.

The recommendations of the panel are summarised below and can be found in full in section five of the report. The recommendations should be read in the context of the broader findings of the clinical review panel as laid out in the key findings section of this report.

Recommendation 1 – clear clinical outcome objectives

The panel recommended that the Trust should clearly articulate the clinical benefits of the EOCC and develop a clear set of outcome measures and targets to include

ambitious, joint specific, outputs in line with national 'Getting it right first time' recommendations and best in practice.

Recommendation 2 – workforce plan

The panel recommended that a comprehensive workforce plan should be developed to encompass the recruitment, retention, training and development of workforce for the future of the service. The panel recommended that there should be a definitive rota for elective and emergency on-call with consultant and junior doctor cover for weekend, bank holidays and appropriate uplift for peri-operative medical care including ortho-geriatric and anaesthetist cover.

Recommendation 3 – clinical pathway redesign

Whilst recognising that work had already been undertaken in the redesign of clinical pathways, and that full implementation was some way off, the panel recommended that further work be undertaken to develop high quality efficient patient pathways for elective orthopaedic surgery and processes developed to ensure that the EOCC beds and theatres were specifically used for elective orthopaedic care. The panel agreed that the need for appropriate clinical input was given consideration and carefully balanced against the supported intent to reduce the number of pre-operative hospital attendances by the patient. The panel recommended that ESNEFT ensure that the community Musculoskeletal (MSK) teams from all parts of the STP/ICS geography were seamlessly linked in to deliver smooth patient pathways.

Recommendation 4 - engagement

The panel recommended that the Trust continues with staff engagement, including the community musculoskeletal workforce to ensure that all staff in and out of the hospital were genuinely part of the clinical team.

Prior to the formal consultation, the Trust should also continue its engagement with patient and carer groups and other stakeholders including the East of England Ambulance Service. As planned, the Trust should continue to validate the travel

impact assessments and understand how it can support those patients that will have an increased travel distance.

Recommendation 5 – patient access support services

The panel acknowledged that a significant amount of work had already been undertaken and commended the Trust on its support and funding of voluntary and third sector transport providers, particularly for patients from the Tendring District area. The panel however wished to recommend that further work was undertaken to assess and improve the access of services for patients.

Recommendation 6 – support services

The panel recommended further work was undertaken to ensure that all support services and systems are fully developed to support implementation of the plans. This included information technology (IT), pharmacy and transport, support services that are essential to safe patient pathways.

The recommendations above should be read in the context of the broader findings of the clinical review panel as laid out in the key findings section of this report.

End.

1. Foreword by Clinical Senate Review Panel Chair

The East Suffolk and North Essex NHS Foundation Trust (ESNEFT) invited the East of England Clinical Senate to review its proposals to improve patient pathways and develop a single Elective Orthopaedic Care Centre. The Trust faces significant challenges, as does the NHS more widely, in providing sustainable high-quality services into the future for patients with rising demand, workforce challenges and tight finances.

I would like to thank the ESNEFT team for providing clear and comprehensive information to the panel in advance of the panel discussion. I would also like to further thank them for covering the key lines of enquiry identified during the pre-panel teleconference during their presentation and for their open and honest response to the Clinical Senate review panel's questions.

The proposals put forward were very much supported by the clinical review panel. The potential benefits of consolidating and ring-fencing elective orthopaedic beds, theatres and teams in a purpose-built facility for patients and staff are very significant. This proposal is also supported by National Programmes such as Getting it Right First Time (GIRFT). There is still some way to go in terms of public consultation and the development of the patient pathways and supporting systems and processes but at this stage the panel were of the view that ESNEFT team were very much on track.

The review panel have made six recommendations. In each case the ESNEFT team have already identified these areas as ones that require further work and indeed a significant amount of work has already been undertaken. The review panel hopes that these will help them to provide even more focus to these areas.

I would like to thank all panel members for giving up their time and focusing on the proposals in a highly professional and patient focussed manner. The questions raised in my view were important and insightful. I would also like to thank Sue Edwards and Brenda Allen for their hard work in arranging all elements of the review, including preparation, selecting a high-quality panel and indeed preparing the report.

Finally, I would like to wish the ESNEFT team well, it was clear that they had improving services for patients as their clear focus and these proposals once implemented should deliver.

Dr Bernard Brett

East of England Clinical Senate Chair and clinical review panel Chair

2. Advice request, background and scope of the review

2.1 East Suffolk & North Essex NHS Foundation Trust (ESNEFT) approached the East of England Clinical Senate in May 2019 with a request to review some of the Trust's major strategic plans for service reconfiguration across the hospital sites in Colchester and Ipswich.

2.2 The formation of ESNEFT on 1 July 2018 from the merger of Colchester University NHS Foundation Trust and Ipswich Hospital NHS Trust was a key part of delivering the Suffolk & North Essex Sustainability and Transformation Partnership (STP) plan. One of the STP's objectives was to achieve viable acute hospitals through the redesign of clinical pathways. To support the delivery of this objective, the STP prioritised a £69.3million bid to fund infrastructure improvements for urgent and emergency care and the reconfiguration of elective services.

2.3 It was agreed that both Colchester and Ipswich Hospitals would retain full 24/7 emergency departments, undifferentiated medical emergency admissions and 24/7 consultant-led maternity services. The retention of those core services on both main hospital sites meant that a number of related clinical specialty and diagnostic services would also have to be retained on both sites to support these services. As a result, the scope for radical large-scale clinical service reconfiguration was significantly reduced. The Trust planned to (among other things) reconfigure the delivery of adult elective inpatient orthopaedic care through the development of a single elective care centre and transforming the associated patient pathways.

2.4 Whilst the development of a single elective orthopaedic centre was part of a wider programme of service improvement and related changes to the respective estates, these were outside the scope of this review.

2.5 The scope of this review was limited to the proposed service changes associated with the development of a single elective care centre for adult elective inpatient orthopaedic care and the continued delivery of trauma services (including trauma surgery), orthopaedic day surgery and outpatients on both main hospital sites.

3. Methodology and Governance

3.1 Clinical review panel members (Appendix 2) from the East of England Clinical Senate and patient representatives (experts by experience) were identified and invited to be a panel member. All panel members signed conflict of interest and confidentiality declarations (Appendix 3).

3.2 Terms of Reference for the review were agreed between the East Suffolk & North Essex NHS Foundation Trust (ESNEFT) team and Dr Bernard Brett, Chair of East of England Clinical Senate (Appendix 1).

3.3 The evidence submitted by ESNEFT was discussed at the pre-panel teleconference on 10 September to prepare panel members and discuss potential key lines of enquiry.

3.4 The clinical review panel took place on 18 September 2019. The ESNEFT team gave an overview and context setting presentation to the panel. The proposals were discussed with the panel in more detail, the ESNEFT team responding to questions and providing supporting detail.

3.5 Sections of the draft report were sent to clinical review panel members for review and confirmation of accuracy and to ESNEFT team for review for points of accuracy on 1 October 2019.

3.6 The final draft of the report was submitted to the meeting of the East of England Clinical Senate Council on 15 October 2019. Senate Council agreed that the clinical review panel had fulfilled the Terms of Reference for the review and confirmed the report.

3.7 East of England Clinical Senate will publish this report on its website at the appropriate time as agreed with the sponsoring organisation.

4 Summary of key findings:

4.1 The panel thanked the team for its presentation and its open and honest approach to the questions from the panel. The ESNEFT team were evidently well prepared and had provided a comprehensive evidence document that clearly set out the case for change, the detail of proposals and the work and evidence used to develop the proposals for the single adult inpatient elective orthopaedic care centre (EOCC) for Colchester and Ipswich hospitals.

4.2 The panel heard that the proposal for the EOCC was part of a wider programme of development and, whilst being put forward by ESNEFT rather than the STP/ICS, was a system wide proposal, supported by all partners in the Suffolk and North Essex Integrated Care System (ICS). The proposal for the EOCC for adult inpatient orthopaedics was part of the 'Building for Better Care' programme funded by the £69.3million capital grant (para 2.2).

4.3 As the two hospitals would both retain key core services including day surgery, emergency care including trauma surgery and full range of secondary care services (para 2.3), there were limited options for the radical reconfiguration of most clinical services to a single site. However, as well as being considered an opportunity that would deliver improved facilities for patients requiring elective orthopaedic procedures and improvements for staff, the development of a single centre for elective adult inpatient orthopaedic care was identified as a feasible option that would enable opportunity for other improvements in facilities at both hospital sites.

4.4 ESNEFT confirmed that irrespective of where the EOCC would be sited, patients would continue to have all their required pre-operative outpatient appointments, diagnostics and assessments at their local hospital. The ESNEFT team did however make it clear that it is redesigning the services such that patients were likely on average to require significantly fewer hospital visits before attending for their surgical procedures. Post-operative follow-up appointments and therapy would also continue to be at the patient's local hospital or within their local community and there would be continuity of Consultant for outpatients and surgery.

4.5 The panel heard that the three options put forward for the siting of the new single EOCC, planned to be operational by 2024, had been: a discrete stand-alone unit potentially off-site of either hospital, or on the Colchester Hospital estate or on the Ipswich Hospital estate. The review panel was very supportive of the desire of ESNEFT to develop a significant number of protected elective beds and theatres for elective orthopaedic surgery. This was supported by a range of evidence including the national Getting It Right First Time (GIRFT) programme. The panel posed several questions to explore the merits of developing the elective capacity on site as opposed to building a facility on a geographically discrete site. The panel understood that whilst the latter would bring more certainty regarding protecting the capacity from the possibility of emergency outliers (most likely either orthopaedic trauma patients or general medical outliers) it would potentially necessitate the need to risk stratify patients as there would be no intensive care unit (ICU) facility on site. The former had the advantage of all other services on site including ICU, the full range of diagnostic imaging and other specialties.

4.6 The panel heard that the financial envelope would not enable the building of a discrete unit with sufficient capacity for the anticipated demand. Indeed, the panel heard that there may not be sufficient capital funding to enable the co-location of basic radiological services within the elective care centre, although it also heard that in addition such a facility would not make the most efficient use of radiology radiographer staff. As pre-operative imaging would continue to take place at the patient's local hospital there would be little impact on the imaging service at either site and so additional imaging facilities were not a necessity to provide the relatively small number of post-operative plain images.

4.7 The panel was advised although no formal decision had been made on the location of the EOCC, the option for a discrete off site EOCC had been discounted. ESNEFT explained in detail the potential implications and benefits to patients, other services, the workforce and the estate of siting the centre at either of the hospital sites. It was clear that a final decision on the location of the EOCC would not be made until after a full public consultation.

The ESNEFT team however made it clear that the Trust's preferred option was to build the centre on the Colchester Hospital estate.

4.8 In response to questions around the evidence base for determining the appropriate capacity of a new EOCC, ESNEFT explained the comprehensive modelling undertaken to develop a centre with capacity to deliver a service for 20 plus years. The panel agreed that the long-term analysis regarding anticipated growth in demand was to be commended – whilst both the ESNEFT team and the panel recognised that the number of variables involved meant that this was unlikely to be 100% accurate. The panel tested the rationale for both the number of beds and the numbers of theatres with several questions both checking whether there might be too few or whether there might be too many. The panel was of the view that the estimates for planning were reasonable and the panel felt that at this stage the planned capacity was likely to be appropriate.

4.9 The panel also heard that ESNEFT had undertaken a wide pre-consultation engagement exercise with stakeholders, patient and user groups, including the musculoskeletal (MSK) user group. It had held staff workshops and engagement events and senior clinicians had been engaged in the discussion. Information from the engagement events had also fed into the modelling for the new EOCC.

4.10 In later discussion, the panel noted that it was not clear to what degree ESNEFT's engagement had been regarding the wider proposals for reconfiguration of clinical services for the two hospitals and across the STP footprint, or specifically the proposals for the elective care orthopaedic centre. The panel also noted that there had been no specific mention of involvement with the East of England Ambulance Service Trust (EEAST) to date. The panel felt that although the impact would in all probability be fairly minimal, there did need to be discussions with EEAST on the transport element of the proposals before a formal decision was made on the siting of the EOCC.

4.11 The panel heard that the clinical focus of the EOCC would be knee, hip and shoulder joint replacements and revisions. It would provide at least 48 inpatient beds built to the latest Hospital Building Note standard, at least five new laminar flow operating theatres with the infrastructure for an additional operating theatre to be commissioned at an appropriate future date when required. There would be capacity for around half of the 48 beds to be single, en-suite rooms, which would enhance patient experience and improve infection prevention. The panel questioned the suitability of having no open bays both for reasons of patient choice, but also as open bays offer advantages with regards to the close supervision of higher acuity patients (noting that there was no plan to risk stratify and undertake higher risk procedures elsewhere). The panel were provided with further information with the reassurance that these factors had already been raised by the ESNEFT clinical team and through discussion with clinicians it had been agreed that it would be appropriate to include a small number of four-bed bays.

4.12 The panel supported the proposal for a mix of individual rooms and four bed bays in order to manage the needs of more complex patients, although having carefully managed CCTV, with appropriate consent, to aide the monitoring of higher acuity patients was discussed.

4.13 The panel heard that currently patients for elective orthopaedic surgery could have up to seven outpatient appointments at the hospital before they underwent their operation. ESNEFT planned to put changes in place in the near future to reduce the number of visits significantly in most cases.

4.14 Whilst the panel supported the need to improve the pathway for the patient and reduce waiting times for surgery, it agreed that there was a fine balance to be held between reducing the number of pre-operative hospital attendances and the need for clinical input and to ensure patients had appropriate time, information and opportunity to prepare for surgery. The panel agreed that careful consideration to this should be given when redesigning the pathway but were very supportive of the plan to significantly reduce the number of visits for most patients.

4.15 The panel also heard that in 2018/19 there was a cancellation rate of around 26 per cent for elective orthopaedic surgery – 17 per cent of cancellations (2,088 patients) were more than two days before surgery, five per cent (606 patients) within one to two days of surgery and 441 patients (four per cent) on the day of surgery. The main reasons for short notice cancellations were use of elective theatre lists for trauma patients or use of elective orthopaedic beds for emergency admissions. The panel heard that the EOCC with dedicated operating theatres would reduce the need for cancellations with a stated aim to reduce the need for cancellations for non-clinical reasons. ESNEFT advised that the Trust was also currently failing to meet the 'Referral to Treatment' target (18-week non-urgent consultant led treatment waiting time) with some patients waiting over 26 weeks for appointments - the improved pathway and expected reduction in cancellations should contribute to improvement.

4.16 The panel tested the ability of ESNEFT to ensure its clear statement and intention that the on-site elective capacity would be protected from emergency patient admissions. Geographically the new unit, if located on the Colchester site, would be a significant distance from the emergency admissions area and even further from the general medical and medicine for elderly facilities. There would also be the potential space to increase the bed numbers elsewhere on the site, if required, as escalation areas. The panel heard that a range of measures were being planned and developed that were outside the scope of this current review. The panel heard that a considerable amount of work was being undertaken to ensure a more integrated team across secondary, community, primary and social care. The panel further heard of the ambition to reduce emergency admissions and reduce length of stay with a particular focus on significantly reducing patients suffering from delayed transfers of care.

4.17 The panel agreed that whilst the proposal centred around a new build with improved patient pathways, it was clearly clinically and not financially driven. There was obvious clinical leadership and support for the proposals and there had been engagement with clinical staff. The panel were reassured

that the Orthopaedic leads from both sites were very supportive of the proposals.

4.18 The panel agreed that siting the elective orthopaedic care centre within the Colchester Hospital estate provided the most benefits and potential for further reconfiguration of clinical services to both the Colchester and Ipswich Hospitals and made clinical sense. The enhanced number of laminar flow theatres available on both sites (with the freeing up of capacity formerly used for elective orthopaedics on the Ipswich site rather than new theatres) was also supported along with the aim to increase the proportion of Total Hip Replacement procedures for patients presenting with a fractured neck of femur (the lack of availability of laminar flow theatre capacity was described as one of the significant barriers to achieving this outcome).

4.19 The panel heard that moving elective adult inpatient orthopaedic care into a single centre would affect around 1400 patients a year (out of the Trust's1.8million patient contacts and 100,000 patient procedures a year). ESNEFT acknowledged that irrespective of where the EOCC was sited, it would result in an increase in travel distance for surgery for some patients and that this could cause some concern and inconvenience. The ESNEFT team explained in part of rationale for the Trust's preference to site the EOCC on the Colchester Hospital site included access to the site by public transport, and to minimise the impact on patients who might be most disadvantaged.

4.20 ESNEFT had undertaken travel impact assessments for locating the EOCC at both hospitals, applying the Public Health England 'Shape Tool'[1] to model the travel impact for each site. The tool calculated the travel time on 'rush hour' travel by road and peak time by public transport. The Trust identified that the population that could potentially be most impacted by changes to the service location, depending on the site chosen for the EOCC, were those living in the Tendring and Suffolk Coastal District areas. The Tendring

[1] https://shapeatlas.net/

District area has a relatively socio-economically deprived population with relatively poor public transport infrastructure and poor access to personal transport. Locating the EOCC on the Ipswich site would clearly exacerbate access issues for that population. Access by public transport and road to the Colchester site from the Suffolk Coastal area was significantly easier for patients than access from Tendring to the Ipswich site. The panel was impressed with the work already undertaken to support and fund voluntary and third sector providers in the provision of transport services for the Tendring area. ESNEFT advised that the travel impact assessments would be subject to further scrutiny from both Essex and Suffolk County Councils and continued validation with patient focus groups.

4.21 The panel agreed that more detail on the pre and post-operative care pathways and link with other services, particularly the musculoskeletal (MSK) community elements in and out of the hospital would have strengthened the evidence. The panel was verbally given an example of one consultant's patient conversion rate from referral to surgery shifting from around 30 percent to 70 percent which clearly demonstrated the current effective assessment and referral from the community teams; however no detail of how that worked or how the community MSK team were integrated with the hospital based orthopaedic team was provided. The reference in discussions to community care had been generalised rather than in any specific detail, although the panel noted that it had not followed that up with further questions and did not give the ESNEFT team full opportunity to clarify some of these points (which could potentially have been an area that would have required a panel recommendation). The panel suggested that if detail of community care was not already included in the pre-consultation business case, it would be beneficial to add some detail around that.

4.22 In response to questions about sharing of electronic patient information across the two hospitals, the panel learned that Ipswich Hospital used the patient information system, Evolve, that would be rolled out across Colchester Hospital and the Trust's community hospitals so that records could be read at all sites. ESNEFT planned for all patients to be able to have (read only) access to their own information through Evolve. The intention is

for all sites to use ICE[2] for requesting and reviewing investigations and the associated results. Colchester and Ipswich hospitals currently had different PACS and pathology systems. ESNEFT was clear that it did not under-estimate the task ahead in terms of access to shared electronic patient information but were confident that it would be fully functional before the new EOCC was operational.

4.23 The panel discussed with ESNEFT quality assurance and measurement of patient outcomes. It was not clear from the evidence whether there was an applied framework for quality assurance and measuring patient outcomes, nor whether there were clear outcome targets in place. The panel heard that collecting the questionnaires for the patient recorded outcome measures (PROMS) had proved difficult for this cohort of patients. The ESNEFT team described several outcomes that they expected to improve but as yet did not appear to have set clear targets in relation to these.

4.24 The panel heard that the Trust had a Quality Improvement Faculty and Research and Innovation team and was committed to research. ESNEFT was starting to address clinical variation across the two hospitals through regular joint orthopaedic governance meetings, sharing of audit data and developing solutions. There was shared learning and a multi-disciplinary team approach. The panel was advised that the two site-based matrons and three orthopaedic wards at each hospital were looking at how they could 'twin up' and were keen to work as a single team. This team had been enhanced with a recently appointed Allied Health Professional lead who would work ICS wide, not just across the hospitals.

4.25 The panel agreed that as a priority ESNEFT needed to develop baseline performance and outcome information for the service and a clear set of targets related to intended improvements to outcomes. PROMS information could be one of several sources including GIRFT and national joint registry data that was readily available with national comparators. The panel heard that nationally collected outcome data for both hospitals was mostly well within the 'funnel' – meaning that, in relation to the volume of procedures,

[2] ICE Health Systems – electronic record system

outcomes were not statistically better or worse than the average UK centre. There was however a lower percentage of Total Hip Replacements for fractured neck of femur trauma patients at both sites. The potential of high volume, subspecialty service with protected purpose-built beds and protected laminar flow theatres are significant. The panel felt that ambitious outcome targets ahead of current average performance could be set.

4.26 The panel agreed that whilst ESNEFT was clear in its vision for the service and how the EOCC would bring about improvements in the facilities for elective orthopaedic patients, it had not articulated so well the clinical benefits or improved outcomes for patients of the EOCC.

4.27 The panel heard that all elective orthopaedic surgery would take place in the EOCC, including patients assessed as high-risk. Currently medical opinion was sought after admission for the more frail patients but ESNEFT was scoping the involvement of Ortho-geriatricians in routine pre-operative assessments for those patients in future with the aim to provide clear patient specific pre-admissions management plans. The panel recognised that the number of frail patients for elective orthopaedic surgery was generally low but still felt that there was a need to ensure that there would be adequate Ortho-geriatric ward cover, including out of hours, particularly as the likelihood of joint revision surgery increased (the Trust currently carried out lower than national average joint revision procedures).

4.28 ESNEFT advised the panel that the Trust was looking to introduce more nurse-led services and there were plans to develop an Advanced Care Practitioner workforce to reduce the reliance on junior doctors. ESNEFT anticipated that with new state of the art facilities and access to more sub-speciality training opportunities, the EOCC would be attractive to staff. Working with the Deanery, ESNEFT hoped to increase its training quota. The panel noted that current vacancy rates were already relatively low.

4.29 The panel supported the proposals to develop an alternative workforce, although cautioned that the programme for training should not have an adverse impact on the current service or other clinical services with both

having to find backfill for those in training and having to recruit new staff to replace current staff members moving on to new roles.

4.30 The panel heard that patients in the EOCC would have daily Consultant reviews, including Saturdays. ESNEFT recognised the need for cohesive rostering for surgeons, nurses and allied health professionals across both sites 24/7. ESNEFT confirmed that there would be an on-call Consultant Orthopaedic surgeon at each site and that the on-call surgeon would cover the EOCC. The panel agreed that it could be challenging for one Consultant Surgeon to cover up to 48 post-operative elective orthopaedic patients along with emergency on-call and the associated number of non-elective inpatients. It was further noted that with more sub-specialisation occurring locally and nationally, there will almost certainly be a need for Orthopaedic sub-specialist consultant reviews at weekends.

End of section.

5. Conclusion and recommendations

5.1 In conclusion and to set the context of the recommendations, the clinical review panel made the following response to the questions asked of Clinical Senate by ESNEFT:

5.1.1 The clinical review panel agreed that the proposal did make clinical sense and that once new pathways had been implemented and the new unit built and operational, outcomes for elective orthopaedic patients should improve. The Trust though did need to develop a well described Quality Improvement Framework with clear performance indicators, outcomes and targets. The aim to reduce waiting times for patients both through enhanced patient pathways, with a requirement for fewer pre-operative patient visits along with the development of a high volume elective centre with protection from interruptions and loss of capacity due to emergency workload, was very much supported. The larger clinical teams should mean greater resilience and the concentration of procedures should also provide enhanced training opportunities for all staff.

5.1.2 Furthermore, the panel agreed that it made more clinical sense, would have less impact on access and should provide a wider range of benefits for patients to other clinical services at both Colchester and Ipswich Hospitals if the EOCC was located on the Colchester Hospital estate.

5.1.3 The panel agreed that the long-term analysis regarding anticipated growth in demand was to be commended – whilst both the ESNEFT team and the panel recognised that the number of variables involved meant that this was unlikely to be 100 percent accurate. The panel tested the rationale for both the number of beds and the numbers of theatres with several questions both checking whether there might be too few or whether there might be too many. The panel was of the view that the estimates for planning were reasonable and the panel felt that at this stage the planned capacity is likely to be appropriate.

5.1.4 The panel agreed that the proposed clinical model provided a robust basis for moving forward with the future development of an EOCC and clinically led reconfiguration of orthopaedic services.

5.2 Recommendations

5.2.1 The panel recognised that ESNEFT had identified all areas covered within these recommendations, that it was already working to enhance the proposals in these areas and had already recognised that further work was needed. Nevertheless, the panel felt it was important to encourage ESNEFT to focus on the following:

5.3 Recommendation 1 – clear clinical outcome objectives

5.3.1 The panel was reassured that ESNEFT was already performing well compared to national performance in relation to most performance indicators including those measured by the National Joint Registry and those used in the Getting it Right First Time (GIRFT) programme. The panel however was of the clear view that ESNEFT should clearly articulate the clinical benefits of the EOCC and improved outcomes for patients.

5.3.2 The panel recommended that the Trust develop a clear set of outcome measures and targets, with timelines, to measure and demonstrate its progress and success. Those measures should include a significant reduction in cancellations due to non-clinical reasons, and reductions in referral to treatment timeline breaches. The measures should also include ambitious, joint specific, outputs in line with GIRFT recommendations and best in practice for length of stay and important clinical outcomes such as infection, re-admission and revision rates. The panel also felt that ESNEFT should set ambitious targets for the system to collect PROM data and use this to enhance the service. The panel suggested that ESNEFT consider using community staff to improve the collection of the PROMS information. Recognising that high levels of research involvement and patient recruitment

were linked to better patient outcomes, the panel felt that the ESNEFT team should set ambitious targets for recruitment of patients to research studies.

5.4 Recommendation 2 – workforce plan

5.4.1 The panel heard that many aspects of the future workforce requirement had been thought through, some measures were already being developed and time to full implementation was some way off but agreed that nonetheless a significant amount of development was required in this area. The panel recommended that a comprehensive workforce plan should be developed to encompass the recruitment, retention, training and development of workforce for the future of the service. This should cover medical, nursing and allied healthcare professional staff required for the orthopaedic service, including the appropriate uplift for peri-operative medical care including ortho-geriatric and anaesthetist support.

5.4.2 Specific areas that needed to be developed were around ensuring there was appropriate cover for the new elective treatment centre out of hours and especially at weekends. Up to 48 beds, even if rarely fully occupied at weekends, would require specific consultant, junior doctor, nursing and allied health care professional input at weekends and bank holidays and could not be absorbed within the current workload of on-call and weekend staff. The panel recommended that there should be a definitive rota for elective and emergency on-call with consultant and junior doctor cover for weekends, including Saturdays, Sundays and bank holidays, to meet the requirements of Clinical Standard 8 (ongoing review) [3]. Consideration must be given to the need for the availability of sub-specialist review.

5.5 Recommendation 3 – clinical pathway redesign

5.5.1 The panel recommended that further work be undertaken to develop high quality efficient patient pathways, including the detail of in and out of hospital musculoskeletal physiotherapy services as part of the pathway. Whilst

[3] https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/

recognising that work had already been undertaken to redesign the clinical pathway and that full implementation was some way off, the panel agreed that this must continue to be a key area of on-going focus. The panel recommended that in redesigning the (pre-operative) clinical pathway for elective orthopaedic surgery, the need for appropriate clinical input was given consideration and carefully balanced against the supported intent to reduce the number of pre-operative hospital attendances by the patient.

5.5.2 ESNEFT should develop processes to ensure that the EOCC beds and theatres were specifically used for elective orthopaedic care as this is critical to the delivery of the improved patient outcomes.

5.5.3 The panel recommended that ESNEFT ensure that the community Musculoskeletal (MSK) teams from all parts of the STP/ICS geography were seamlessly linked in to deliver smooth patient pathways.

5.6 Recommendation 4 - engagement

5.6.1 The panel recommended that the Trust continues with staff engagement, including the community MSK workforce to ensure that all staff in and out of the hospital were genuinely part of the clinical team.

5.6.2 The panel further recommended that prior to the formal consultation, ESNEFT continues its engagement with patient and carer groups and other stakeholders including the East of England Ambulance Service. As planned, it should continue to validate the travel impact assessments and understand how it can support those patients that will have an increased travel distance from the chosen site (covered in recommendation 5).

5.7 Recommendation 5 – patient access

5.7.1 The panel recognised that a significant amount of work had already been undertaken and further work was planned to assess the impact of the proposed changes on patient access. Significant mapping work to assess travel times had been done and further County Council input was awaited.

The panel was impressed with the work carried out to support and fund voluntary and third sector providers in the provision of transport services, particularly for the Tendring District area.

5.7.2 The panel agreed that more could still be achieved regarding specific patient groups. The use of patient focus groups was recommended to further test the impact of travel times for patients.

5.7.3 The panel recommended that further work was undertaken to assess and improve the access of services for patients. The panel recommended that ESNEFT considered personalised scheduling for elective orthopaedic surgery appointment times to ensure consideration was given to those patients having to travel the greatest distance to the EOCC.

5.8 Recommendation 6 – support services

5.8.1 The panel recommended further work was undertaken to ensure that all support services and systems are fully developed to support implementation of the plans. This included Information technology (IT), pharmacy and transport.

5.8.2 The ESNEFT team were already developing the Trust and STP/ICS wide plans to improve IT services including the roll out of the Evolve and ICE systems and planned to ensure that PACS images were accessible across all sites. These systems were essential to safe and efficient patient pathways.

End of Section.

APPENDIX 1: Terms of Reference for the review

NHS
East of England
Clinical Senate

Terms of Reference for the

independent clinical review of proposed changes to

adult elective inpatient orthopaedic care at

Colchester and Ipswich Hospitals

for the East Suffolk and North Essex NHS

Foundation Trust

DATE 18 September 2019

CLINICAL REVIEW: TERMS OF REFERENCE

Title: Independent clinical review of proposed changes to adult elective inpatient orthopaedic care at Colchester and Ipswich Hospitals.

Sponsoring organisation: East Suffolk and North Essex NHS Foundation Trust

Terms of Reference agreed by: Andrew McLaughlin, Director of Clinical Strategy Implementation, East Suffolk and North Essex NHS Foundation Trust

Signature

and

Dr Bernard Brett, East of England Clinical Senate Chair, on behalf of East of England Clinical Senate

Signature

Date: 22 August 2019

When is the advice required by? Please provide any critical dates	31st October 2019 (paper deadline for East Suffolk and North Essex NHS Foundation Trust Board of Directors meeting 7th November 2019)
What is the name of the body / organisation commissioning the work?	East Suffolk and North Essex NHS Foundation Trust working in partnership with Ipswich and East Suffolk CCG and North East Essex CCG.
How will the advice be used and by whom?	To provide an independent clinical view on the impact of the proposed service change to inform the decision making of ESNEFT Board of Directors, North East Essex CCG Governing Body, Ipswich and East Suffolk CCG Governing Body, NHS England and NHS Improvement.
What type of support is Senate being asked to provide: a) Assessment of clinical services b) Early advice to inform a clinical service model c) Review of proposed clinical model /s d) Support for case for change, including the appraisal of the clinical evidence within e) Informal facilitation to enable further work f) other	c) Review of proposed clinical model.
Is the advice being requested from the Senate a) Informal early advice on developing proposals b) Early advice for Stage 1 of the NHS England Assurance process c) Formal clinical review to inform Stage 2 of the NHS England Assurance process and/ or your Consultation Business Case d) Other	c) Formal clinical review to inform Stage 2 of the NHS England Assurance process and to inform preparation of the Pre-Consultation Business Case.
Does the matter involve revisiting a strategic decision that has already been made?	No.
Is the matter subject to other advisory or scrutiny processes?	The proposed service change will be subject to scrutiny through the ESNEFT Board of Directors, North East Essex CCG Governing Body, Ipswich and East Suffolk CCG Governing Body, Joint HOSC (Essex and Suffolk), Suffolk and North East Essex ICS, NHS England and NHS Improvement.

Clinical review panel members

Members of the clinical review panel sit in their own personal or professional capacity; they do not represent the opinion of their employing or professional body. All clinical review panel members sign an agreement of confidentiality and declare any (potential interests).

Clinical Review Panel members	
Dr Bernard Brett (Chair)	Clinical Senate Council Chair, Deputy Medical Director and a Consultant in Gastroenterology and General Internal Medicine Norfolk and Norwich University Hospitals NHS FT
Andy (Andrea) Assan	Expert by Experience, Cambridgeshire
Matthew Carr	Physiotherapist, Clinical Director, Sussex MSK Partnership East
Alan Hancock	Expert by Experience, Milton Keynes Clinical Senate Council member
Heather Howman	Deputy Director of Quality, East Coast Community Healthcare (ECCH)
Mr Graham Keene	Consultant Orthopaedic Surgeon Addenbrooke's Hospital
Mr Devender Khurana	Consultant Orthopaedic Surgeon, James Paget Hospital
Dr Ramanathan Kirthivasan	Care of Elderly Consultant, Broomfield Hospital Chelmsford
Dr Ellie Makings	Anaesthetist & Regional Medical Examiner, East of England Clinical Senate Council member
Dr Christine Moss	GP, Clinical Director for West Essex CCG & Clinical Senate Council member
Linda Purdy	Consultant Nurse, Acute Medicine, Queen Elizabeth 11 Hospital Kings Lynn
Mr Paul Tisi	Medical Director and Responsible Officer, Consultant Vascular and General Surgeon Bedford Hospital NHS Trust. Clinical Senate Council member

Aims and objectives of the clinical review

The formation of ESNEFT on 1 July 2018, from the merger of Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust, was a key part of delivering the Suffolk & North East Essex Sustainability and Transformation Partnership (STP) plan. The STP's objective is to achieve viable acute hospitals across what is now designated as an Integrated Care System (ICS) through the redesign of clinical pathways around outcomes, underpinned by innovation. To support delivery, the STP prioritised a £69.3 million bid to fund infrastructure improvements for urgent & emergency care and the reconfiguration of elective services to deliver significant benefits identified during public, staff and stakeholder engagement. This programme is called Building for Better Care.

In developing the case for the formation of ESNEFT, it was agreed that both Colchester and Ipswich hospitals should retain full 24/7 emergency departments, undifferentiated medical emergency admissions and 24/7 consultant-led maternity services. The retention of these core services on both main hospital sites meant that a number of related clinical speciality and diagnostic services would also have to be retained on both sites to support these services. As a result, the scope for radical, large scale clinical service reconfiguration to deliver benefits for patients and to improve clinical, workforce and financial sustainability was significantly reduced. That said, by maintaining access to 24/7 urgent and emergency care on both main sites along with convenient local access to outpatients, diagnostics, daycase surgery and follow-up care ESNEFT's clinically-led Clinical Advisory Group identified that there is scope to deliver patient benefits by centralising some aspects of adult, elective inpatient care.

Therefore, in line with the local STP vision and national guidance such as 'Getting it right first time' (GIRFT), the Trust has developed a plan to reconfigure the delivery of adult elective inpatient orthopaedic care through the development of a single 'elective care centre' (ECC). The consolidation of adult elective inpatient orthopaedic care in an ECC aims to improve the overall experience for patients, their families and carers in terms of the quality of care, the physical environment, waiting times, cancellation rates, infection rates, length of stay whilst maintaining sustainable, convenient access to the full range of orthopaedic procedures. This plan will be subject to public consultation.

There are no plans to make any changes to the continuing availability on both main sites of orthopaedic outpatient care, diagnostics and trauma care. However, it will mean that around 800 of the almost 100,000 elective inpatients treated each year will receive their elective care at a different site from where it would previously have been provided. All other associated care on the elective inpatient orthopaedic pathways will continue to be made available at either main site to suit the patient.

The East of England Clinical Senate is asked to undertake a clinical review of the proposed changes to adult elective inpatient orthopaedic care to provide an independent assessment of the impact the service changes may have and to identify any additional considerations the Trust should make during the development of plans.

The outcome of the review will be used to inform the proposed service changes to ensure they deliver real benefits to patients whilst avoiding any significant risks to care.

Scope of the review

The scope of this review is limited to the proposed service changes associated with the development of a single Elective Care Centre for adult elective inpatient orthopaedic care and the continued delivery of trauma services (including trauma surgery), orthopaedic day surgery and outpatients on both main hospital sites.

Out of scope

Clinical Senate is not asked to review any other clinical services or changes in the clinical estate or to include consideration of any financial implications.

Purpose of the review

Clinical Senate is asked to review the available evidence, discuss with the members of the programme and make appropriate recommendations from its findings.

The central question/s Clinical Senate is/are being asked to address in this review are:

1. Does the creation of a single elective care centre for ESNEFT and the proposed model and pathways for trauma & orthopaedics make clinical sense and, based on the evidence provided, offer the potential to deliver further improvements in clinical effectiveness and/or clinical sustainability?

2. On the basis of the evidence provided, do the proposed model and pathways for trauma & orthopaedics offer look likely to deliver safe, high quality services and outcomes for patients once implemented?

3. Does the proposed clinical model form a robust basis for moving forward with the future development of the single elective care centre and clinically-led reconfiguration of orthopaedic services?

When reviewing the case for change and options appraisal the clinical review panel (the panel) should **consider whether these proposals deliver real benefits to patients. The panel should also identify any significant risks to patient care in these proposals.** The panel should consider benefits and risks in terms of:

- Clinical effectiveness
- Patient safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes.

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?

- Do the proposals support better integration of services from the patient perspective?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The clinical review panel should assess the strength of the evidence base of the case for change and proposed models.

Timeline

The clinical review panel will be held on Wednesday, 18th September 2019. See key dates schedule at Appendix a) for all full timeline.

Reporting arrangements

The clinical review panel will provide a report to Clinical Senate Council which will ensure the panel met the agreed Terms of Reference, agree the report and be accountable for the advice contained in the final report.

Methodology

The review will be undertaken by a combination of desk top review of the documentation, a pre-panel teleconference to identify the key lines of enquiry and a review panel meeting to enable presentations and discussions to take place.

Report

A draft report will be made to the sponsoring organisation for fact checking prior to publication no later than 1 October 2019.

Comments/ correction must be received from the sponsoring organisation within **five working days**.

Final report will be submitted to Clinical Senate Council 14 October 2019 to ensure it has met the agreed Terms of Reference and to agree the report.

The final report will be submitted to the sponsoring organisation following the Council Senate Council meeting of 14 October 2019. The sponsoring organisation forthwith becomes the owner of the report.

Communication, media handling and Freedom of Information (Act) requests

Communications will be managed by the sponsoring organisation. Clinical Senate will publish the report once the service change proposal has completed the full NHS England process, or at a time that is appropriate to the proposals. This will be agreed with the sponsoring organisation. The sponsoring organisation, as the owner of the report and any evidence and or data provided for the review, will be responsible for handling any formal requests for information under the Freedom of Information Act 2000, irrespective of whether the request is received by either Clinical Senate or sponsoring organisation. (note: NHS England is the statutory body with responsibility for FOI requests received either directly or by Clinical Senate and will be advised of all such requests received directly by Clinical Senate and confirmation that the sponsoring organisation will be responding to the request).

Resources

The East of England Clinical Senate will provide administrative support to the clinical review panel, including setting up the meetings and other duties as appropriate.
The clinical review panel may request any additional existing documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

Accountability and governance

The clinical review panel is part of the East of England Clinical Senate accountability and governance structure.
The East of England Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation, who are the owners of the final report.
The sponsoring organisation remains accountable for decision making but the clinical review panel may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, but is not limited to:

- relevant public health data including population projections, health inequalities, specific health needs,

- activity date (current and planned)
- internal and external reviews and audits,
- relevant impact assessments (e.g. equality, time assessments),
- relevant workforce information (current and planned)
- evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Long Term Plan, NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG plans and commissioning intentions, STP implementation plans).

The sponsoring organisation will provide any other additional background information requested by the clinical review panel.

ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.

iii. undertake not to attempt to unduly influence any members of the clinical review panel during the review.

iv. be responsible for responding to all Freedom of Information requests.

v. arrange and bear the cost of suitable accommodation (as advised by clinical senate support panel) for the panel and panel members.

Clinical Senate Council and the sponsoring organisation will

i. agree the Terms of Reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will

i. appoint a clinical review panel this may be formed by members of Clinical Senate Council and Assembly, external experts, and / or others with relevant expertise. It will appoint a Chair of the review panel

ii. endorse the Terms of Reference, timetable and methodology for the review

iii. consider the review recommendations and report (and may wish to make further recommendations)

iv. provide suitable support to the panel and

v. submit the final report to the sponsoring organisation

vi. forward any Freedom of Information requests to the sponsoring organisation.

Clinical review panel will

i. undertake its review in line the methodology agreed in the Terms of Reference

ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The panel will subsequently submit final draft of the report to Clinical Senate Council.

iv. keep accurate notes of meetings.

Clinical review panel members will undertake to

i. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information

ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology).

iii. contribute fully to the process and review report

iv. ensure that the report accurately represents the consensus of opinion of the clinical review panel

v. 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 of the clinical review panel and the Head of Clinical Senate, any conflict of interest that may materialise during the review.

Appendix a – Key dates schedule

Action	Date	Who
1. Terms of Reference for review completed, agreed and signed off	**No later than early 14 August 2019**	ESNEFT team and Senate
2. All panel members identified and confirmed, confidentiality	No later than**14 August 2019** *Before panel sent evidence*	Sue Edwards

agreements and declarations of interest signed		
3. All papers and evidence for the review panel to be with Sue Edwards	No later than end of **29 August 2019**	ESNEFT team
4. Panel papers etc to panel members	**02 September 2019**	Sue Edwards
5. Pre panel teleconference call	**DATE** (poss 10/9/19 tbc)	Panel members only – ESNEFT not involved-
6. Lines of Enquiry / Agenda for Clinical Panel review day issued	No later than **12 September** (if 5 above is 10/09)	SE to ALL
7. Clinical Panel Review	**18 September 2019 (confirmed)**	ALL – panel members & ESNEFT team (max 5 plus AT)
8. Draft report to ESNEFT lead for points of accuracy	**No later than 01 October 2019**	SE/Chair ESNEFT response with 5 days
9. Clinical Senate Council consider report	**15 October 2019**	Senate Council

APPENDIX 2: Membership of the clinical review panel

Clinical Review Panel Chair:

Dr Bernard Brett
Dr Bernard Brett, Chair of East of England Clinical Senate, is Deputy Medical Director and a Consultant in Gastroenterology and General Internal Medicine based at the Norfolk and Norwich University Hospitals NHS Foundation Trust, and also works at the James Paget University Hospitals NHS Foundation Trust.

Bernard has held several senior management posts over the last fifteen years including that of Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal lead. He continues with an interest in Appraisal and Revalidation. Bernard has spoken at regional and national meetings on the topic of 7-day working and been an invited speaker on the topic of improving colonoscopic adenoma detection rates.

Panel Members:

Andrea Assan
With a background of 20 years Local Government experience in Adult and Children's services, Andrea has been a board member of the local HealthWatch since it was established in 2013. Her eldest daughter has learning and physical disabilities and because of her experiences, having left work, she decided to do voluntary work to try to make a difference to help improve both health and social care in our area. As part of her HealthWatch role she sits on a number of boards including Bedfordshire Child Death Overview Panel, East of England Ambulance Trust Community Engagement Group, Carers Partnership Board, Royal College of GP's Faculty board and Integrated Pain Service User Group.

Matthew Carr
Matthew Carr is a physiotherapist with 15 years of clinical experience. He works as an Advance Physiotherapy Practitioner with a specialist interest in the management of complex spinal conditions. He is Clinical Director for Sussex MSK Partnership East. This organisation is responsible for the coordination and delivery of all MSK clinical services across a large section of East Sussex. Matthew's leads the clinical strategy for the partnership, engaging with the full range of clinical teams to enable and ensure the highest quality of MSK healthcare across this region. Matthew is currently completing a Masters in Clinical Research at the University of Brighton, supported by the National Institute of Health Research, to develop a framework of workplace learning which improves clinical standards in MSK practice. He has a passion for ensuring the highest quality of healthcare and has presented recently at the European region of the world congress of physiotherapy and at the European health management association on this topic.

Ellie Devine
Ellie Devine is Head of the South West Clinical Senate. She has worked in the NHS for over 14 years. Prior to the Clinical Senate she worked as a Transformation Programme Manager for the South West Commissioning Support Unit and as a Planned Care and Cancer Services Commissioner for the Bristol, North Somerset and South Gloucestershire PCTs. Before moving to the South West Ellie worked as an operational manager in the surgical divisions at St George's Hospital Trust, London.

Dr Alan Hancock
In retirement since 2014, Dr Hancock is active in civil society, primarily in the health sector, where he has a particular interest in integrated health and social care, primary care and acute care. Becoming a Patient Champion of the National Association for Patient Participation in 2013, he was Chair of his local Patient Participation Group for three years, and a founding Trustee of the recently independent Healthwatch Milton Keynes, where he is currently a Deputy Chair. He was elected a Public Governor of Milton Keynes University Hospital Foundation Trust in 2016. Alan is an expert by experience member of Clinical Senate Council.

Heather Howman
Heather currently works as a Deputy Director of Quality and Data Protection Officer for East Coast Community Healthcare. She is a very experienced clinician having worked for over thirty years in health care and has experience of working in the acute, community and Primary Care Networks. Heather has a keen interest in governance, patient experience and safety and has successfully led the organisation through a *Good* CQC inspection where some areas were seen as *outstanding*. She has a strong track record in managing clinical and information governance through large scale transformation.

Heather currently holds a large portfolio including Research, audit, patient safety, clinical and information governance, clinical claims, complaints and is the learning from deaths lead for the organisation. She is a member of the QNI Director network.

Mr Graham Keene
Mr Graham Keene is a Consultant Trauma and Orthopaedic Surgeon at Addenbrooke's Hospital (Cambridge United Hospitals NHS Foundation Trust). He has been in post for over 20 years, but was also trained in East Anglia. His clinical experience includes general orthopaedic trauma and his elective experience involves hip and knee surgery. He was Clinical Director of Trauma and Orthopaedic Surgery at Addenbrooke's Hospital for 4 years.

Mr Devender Khurana
Mr Khurana has been working in the NHS for last 25 years. Present job role is as a Consultant Orthopaedic Surgeon with special interest in Knee Revision surgery. He is also chair of LNC at JPUH NHS Trust.

Mr Khurana has been a member of EOE Clinical Senate for more than five years. He has been recently elected a Staff Governor at the JPUH. His passion is "Quality improvement" and "safe care". He is also the FTSU Guardian at his trust.

Dr Ramanathan Kirthivasan
Dr Kirthivasan has served the NHS as a consultant in Medicine with an interest in Stroke since 2003. He took a hiatus from NHS for 4 years to set up a comprehensive stroke service in India upon invitation and was helpful in setting up a vision for a national database for strokes in India. He returned to the UK after this and is currently a Clinical Director in Medicine and a Joint Stroke lead in the STP.

Dr Ellen Makings
Dr Ellen Makings MBBS, FRCA, FFICM, RCPathME is the Lead Medical Examiner at the Royal Papworth Hospital and the James Paget University Hospital. She has been a Consultant in Anaesthetics &Intensive Care for 15 years at Mid Essex Hospitals NHS Trust where she was then appointed as Medical Director in 2017. Her areas of interest in Critical Care are patient safety and recovery from critical illness. She has been a

Medical Examiner at Mid Essex for 8 years, one of the original Department of Health pilot sites for the Medical Examiner system.

In 2019 she has become a full time Medical Examiner working at James Paget and Royal Papworth Hospitals. She is passionate about the Medical Examiner process and its contribution to patient safety. She is a member of the Faculty of the Royal College of Pathologists providing the training of future medical examiners and a member of Clinical Senate Council.

Dr Christine Moss
Christine has worked as a GP Principal in Buckhurst Hill, Essex, for more than 30 years and has been involved in service development and commissioning since 2002. She is Clinical Director for West Essex CCG and has specific responsibility for clinical effectiveness, including service restrictions and the Right Care approach to transformation. She is also Cancer clinical lead for Herts and West Essex STP. Christine is a member of Clinical Senate Council.

Linda Purdy
A registered nurse for 30 years, Linda is a Nurse Consultant in Acute Medicine and has historically worked in Emergency and Acute Care settings. Formerly for many years in the Emergency Department (ED), promoting quality, evidence-based care and multiprofessional teamwork to enhance the patient's journey through the ED to enduring secondary care or to discharge. In 2016 she moved to Acute Medicine as a Nurse Consultant, working across the Acute Medical Floor and working collaboratively with the Senior Nursing Team and Consultant Medical team on project management and innovation developments to improve patient care delivery and safety.

Mr Paul Tisi
Mr Paul Tisi is Medical Director and Responsible Officer at Bedford Hospital NHS Trust. He was appointed as Consultant Vascular and General Surgeon at Bedford Hospital and Luton and Dunstable University Hospital in 2001. Aside from his board role he maintains a clinical practice with specific interest in management of venous disease. Paul is a member of Clinical Senate Council.

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In attendance at the panel: ESNEFT Team:

Rebecca Driver	Director of Communications and Engagement
Kay Hamilton	Associate Director of Nursing
Dr Crawford Jamieson	Medical Director
Mr Mark Loeffler	Consultant Orthopaedic Surgeon, Colchester Hospital
Andrew McLaughlin	Director of Clinical Strategy Integration
Mr Graham Myers	Consultant Orthopaedic Surgeon, Ipswich Hospital
Anna Turner	Head of External Engagement

Clinical Senate Support Team:

Sue Edwards	East of England Head of Clinical Senate, NHS England
Brenda Allen	East of England Clinical Senate Senior Project Officer

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests.

Prior to the panel day, panel members all claimed not to have a a) Personal pecuniary interest b) Personal family interest c) Non-personal pecuniary interest or d) Personal non-pecuniary interest.

During panel discussions, Dr Bernard Brett, Mr Devender Khurana and Dr Ellen Makings wished to record that their respective employing Trusts bordered on the Suffolk boundary and that the proposals could in future, cause them to have a potential conflict of interest. However, for this panel it was considered this was not a conflict and there was no reason for them to withdraw from the panel (the ESNEFT team had been aware of their circumstances prior to the panel).

APPENDIX 4: Review panel agenda

A G E N D A

Independent clinical review panel

for East Suffolk & North Essex NHS Foundation Trust

Date: Wednesday 18 September 2019. **Time:** 09.15 to 16.30hrs for panel members & 09.50hrs to 13.00 hrs for ESNEFT team

Venue: Bourne Bridge Room, Granta Centre, Granta Park, Cambridge CB21 6AL

'Stage 2 review[4]' in response to the proposals for changes to adult elective in-patient orthopaedic care at Colchester and Ipswich Hospitals, Clinical Senate is being asked to address the following questions:

4. Does the creation of a single elective care centre for ESNEFT and the proposed model and pathways for trauma & orthopaedics make clinical sense and, based on the evidence provided, offer the potential to deliver further improvements in clinical effectiveness and/or clinical sustainability?

5. On the basis of the evidence provided, do the proposed model and pathways for trauma & orthopaedics offer look likely to deliver safe, high quality services and outcomes for patients once implemented?

6. Does the proposed clinical model form a robust basis for moving forward with the future development of the single elective care centre and clinically-led reconfiguration of orthopaedic services?

[4] NHS England NHS Improvement service change assurance process

Time	Item
09.15 – 09.30	**Registration & arrival – panel members**
09.30 - 09.50	Welcome, introductions & outline of the proceedings for the review panel from panel chair Dr Bernard Brett
09.50 – 10.00	East Suffolk & North Essex FT (ESNEFT) team welcome & introductions
10.00 - 10.30	Overview presentation 30 mins by ESNEFT team to panel
10.30 – 11.15	General questions from panel to ESNEFT team
11.15 – 11.30	Short break
11.30 – 13.00	Panel questions & informal discussion with ESNEFT
13.00 – 13.40	Lunch
13.40 – 16.00	a) Panel discussion b) Panel summary – key findings and recommendations (to include working break as appropriate)
16.00 - close	Panel summary – key findings and recommendations

Key Lines of Enquiry – raised on the pre-panel call 10 September 2019

1) **Clinical outcomes: w**hat are the plans to address variation in outcomes across the two sites, what is the Quality Assurance framework, are patient outcome targets going to be set/agreed. Will there be any risk stratification of patients (will higher risk patients be managed differently?) Will there be easy access to ICU if required? Femoral neck fracture patients, who require a total hip replacement- will a suitably skilled hip surgeon still be available in the trauma theatre every day in Ipswich for these patients, if elective surgery is moved off site?

2) **Workforce: o**ut of hours cover of elective patients: Only one of the two hospitals will now have an ECC for orthopaedic surgery. At night and at weekends, will the current medical on-call staff will look after these patients on the ward at the ECC. There will then be significantly less work for Ipswich, but significantly more work for those doctors at Colchester with the new ECC. What are plans for orthogeriatric cover?

3) **Activity and capacity:** clarification of activity numbers and number of patients affected; ICU capacity at Colchester Hospital, clarification of whether the new unit provides 48 additional new beds, will the beds be ring-fenced for elective care and how will you prevent them being taken up by emergency medical or surgical patients or winter pressures. Laminar flow theatres

4) Access: preservation of patient choice; travel times (real time or computer generated), modelling of (potentially longer) LoS for those with furthest distance from ECC, patient / public involvement in the governance structure especially the ECC engagement group.

5) **Patient Pathway –** how will the service link in with local MSK hubs to ensure appropriate referrals (with high conversion rates to surgery) and appropriate and timely physiotherapy post discharge from surgery.

Next steps – information for clinical review panel members:

1) A draft report will be sent to ESNEFT team and clinical review panel members for points of accuracy check no later than 1 October 2019 with five day turnaround for panel members and seven day turnaround for ESNEFT team.

2) Final draft report will be provided for specially convened Clinical Senate Council meeting on 15 October 2019 for Council to confirm that the clinical review panel met the Terms of Reference for the review (NB Council cannot make any material changes to the report or its recommendations but may make additional comment or recommendations.)

Final report provided to ESNEFT team by 17 October 2019.

End of report.