NHS
West Midlands
Clinical Senate

# West Midlands Clinical Senate
# Walsall Urgent Care Review

# Stage 2 Clinical Assurance Review
# Panel Final Report

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## Stage 2 Clinical Assurance Review Panel Final Report

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NHS West Midlands Clinical Senate

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# 1. Panel Chair / Clinical Senate Chair Foreword

I have been fortunate to chair a review of the Urgent Care Centre services for Walsall. The CCG is the organisation responsible for commissioning care services for the population of Walsall. Like many areas, Walsall is faced with increasing demands for services and financial pressure. For this reason, it is even more important that the NHS continues to change the way it works to respond to the needs of the people who use it, adopting best practice and providing evidence based services. It is the role of the commissioner to ensure that they regularly review the services commissioned to ensure they meet the needs of their populations, effecting service reconfigurations when needed. Within this duty they have to ensure they are making the most efficient and effective use of resources. This was a key driver in the Urgent Care centre review.

A full and multi-disciplinary panel sat for 2 days, the morning of day 2 was spent on a very helpful site visit to the Urgent Treatment Centre in Walsall town and Walsall Hospital Urgent Care Centre. This helped the review team to obtain a good understanding of the current service and the proposal being made.

This review was undertaken by a mixture of clinicians, patient representatives, commissioners of urgent care services and providers or emergency care. Significant debate occurred particularly over impact on patients who lived in the town centre and the capacity of the A&E department at Walsall Manor.

We also took into consideration the National review of Urgent Care services which states that patients and the public are often confused by the mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service.

All were convinced that this proposal to close the Walsall town centre UTC and increase capacity of the UCC at Walsall Manor, was in the patient's interest and should help to improve the quality of care offered, but is subject to closer working with the A&E department at Walsall Manor, as well as recruitment to key posts.

Decisions like this are always difficult and require good communication and engagement with patients, staff and local residents.

**Dr Masood Nazir**

**GP, CCIO (Birmingham & Solihull CCGs) & National Clinical Lead – Digital Transformation of Primary Care NHS England**

## 2. Advice Request

The West Midlands Clinical Senate was asked by Walsall CCG to provide independent clinical advice on the proposed consolidation of Walsall Urgent Care Services on the Walsall Manor Hospital site.

The request was made in July 2017 and clarification of the scope of the request was developed during January 2018.

The West Midlands Clinical Senate was asked to review the documentation and evidence to:

a) provide a clinical opinion of the proposed provision of Urgent Care Primary Care Services within Walsall

b) consider the proposed consolidation of Urgent Care Services co-located on the Walsall Manor Hospital site

c) Ensure proposals comply with national and local guidance and strategy

The scope of the review did not include consideration of Walsall emergency care services, primary care services or any financial implications, either negative or positive. However, the impact of the proposed consolidation of Urgent Care Services on the Walsall Manor Hospital site on emergency care and primary care services was considered.

The evidence and information provided for the clinical review panel was provided by Walsall CCG.

(NB. The **background** for the Walsall Urgent Care Services consolidation review is detailed in **Section 4** of the report).

# 3. Methodology and Governance

## 3.1 Terms of Reference

3.1.1 Walsall CCG consolidation of Walsall Urgent Care Services was formally adopted onto the Clinical Senate work programme by the Clinical Senate Council in July 2017, following a presentation to the council and request for NHS England Stage II Clinical Assurance. The Independent Clinical Review Team (ICRT) Chair and Vice Chair was appointed by the council. A request to the West Midlands Clinical Senate from Walsall CCG for NHS England Stage II Clinical Assurance was formally received on 27th July 2017.

3.1.2 Terms of reference for the Council's work were developed as per NHS England guidance (See Appendix 1). This included the approach for formulating the advice and the overall process through which advice and recommendations would be developed. The initial draft of the terms of reference stated the aim as 'assess and confirm the clinical quality, safety and management of risks, patient experience, including access to services, and patient reported outcomes of the proposed consolidation of Urgent Care Services was shared with Walsall CCG; this ensured that the advice which the Clinical Senate had been asked to provide, and the approach to formulating it, was transparent to all stakeholders. Discussions took place from 8thJanuary to 22nd January 2018 between the Clinical Senate, and Walsall CCG to shape and agree the TOR. NHS England sense checked the TOR at the Executive Directors Meeting on the 17th January 2018. The Terms of Reference for the review were signed off by Professor Simon Brake, Chief Officer Walsall CCG and Professor Adrian Williams Chair of West Midlands Clinical Senate.

## 3.2 Process

3.2.1 The process to formulate the advice was led by Dr Masood Nazir and Professor Adrian Williams, the process was guided by the Clinical Senate Review Process Guidance Notes (2014).

3.2.2 The Clinical Senate formulated advice between January and February 2018. An Independent Clinical Review Team (ICRT) was established to assist the Senate. This included members from professional groups with specific knowledge and expertise in the areas which the Clinical Senate had been asked to provide advice. To ensure any advice given was robust, transparent and credible; the team included clinical experts from within and outside the West Midlands area (See Table 1) and (Appendix 1& 2). A Confidentiality agreement and potential conflicts and associations were declared during the process. These are recorded in Appendix 1&2)

3.2.3 Review dates were held on 24th January and 8th February 2018 (See Appendix 3). The ICRT review documentation was provided by Walsall CCG Urgent Care Services Review Team (See Appendix 4).

Presentations relevant to the review were made from key members from Walsall Urgent Care Services.

3.2.4 At the end of the first day the panel requested that a site visit should be carried out to inform discussions on the second day. Five members of the panel were appointed to undertake the site visit on 8th February. The five panel members met with the multi-disciplinary teams involved in the Urgent Care Services pathway at the designated UCC's at the town centre and Walsall Manor Hospital. The five panel members met with Primecare representatives - Dr Shah Regional Medical Director, Simon Hipkiss, Clinical Service Manager, Paul Minton, Urgent Care Manager; representatives from Walsall CCG (including the Clinical Chair) and Emergency Department representatives including consultants, ED Clinical Director and Triage Nurse(s).

3.2.5 This report presents the key issues that were discussed and the clinical opinion formed on the proposed consolidation of Walsall Urgent Care Services from the evidence presented (documentary and verbally). It is not intended to be a comprehensive record of the discussion.

## 3.3 Scope and Limitations

3.3.1 The scope of the review was agreed between Walsall CCG and the West Midlands Clinical Senate as per TOR. The conclusions are limited to the evidence presented, and are not exhaustive.

**Table 1 Independent Clinical Review Team Members**

| Name | Position | Organisation |
|---|---|---|
| Dr Masood Nazir<br>Chair ICRT | Chair Independent Clinical Review Team<br>GP<br>National Clinical Lead<br><br>Chief Clinical Information Officer & SRO<br><br>Clinical Information Lead and | <br><br>Hall Green Health<br>Digital Transformation of General Practice NHS England<br>Your Care Connected programme<br><br>Birmingham CrossCity CCG Governing Body |
| Prof Adrian Williams<br><br>Vice Chair ICRT | Chair of West Midlands Clinical Senate and Professor of Neurology | University Hospitals Birmingham NHS Foundation Trust |

**Members:**

| Name | Position | Organisation |
|---|---|---|
| Dr Helen Carter | Deputy Director - Healthcare Public Health & Workforce | Public Health England |
| Dr Kamal Nathavitharana | Associate Postgraduate Dean | Health Education England |
| Mark Millins | Associate Director Paramedic Practice<br><br>Chair | Yorkshire Ambulance Service<br><br>NHS Ambulance Services Lead Paramedic Group |
| Dr Julian Povey | Chair | NHS Shropshire CCG |
| Dr John Oxtoby | Executive Medical Director | University Hospitals of North Midlands NHS Trust |
| Dr James France | Consultant Emergency Medicine (A&E) | Worcestershire Royal Hospital |
| Mr Philip Toozs-Hobson | Consultant Gynaecologist | Birmingham Women's and Children's Hospital NHS Foundation Trust |
| Mr Peter Fahy | Director of Adult Services | Coventry City Council |
| Mr Jason Evans | Commissioning Manager for Urgent Care | Dudley CCG |

| | | |
|---|---|---|
| Mrs Shilpi Rahman Practice/ Manager Business Partner (non-clinical) | Practice/ Manager | Marshall Street Surgery<br>Smethwick<br>West Midlands |
| Dr Sneha Devlukia | Clinical Director | Health Inclusion Matters CIC |
| Satyan Kotecha | Pharmacist | NHS England<br>K&K Healthcare Ltd |
| Simon Radley | Consultant Surgeon, General & Colorectal Surgery | University Hospital Birmingham |
| Mrs Gillian Stewart | Patient Representative | N/A |
| Mr Peter Pinfield | Patient Representative | N/A |
| ***In attendance*** | | |
| Mrs Angela Knight Jackson | Head of Clinical Senate | West Midlands CN and Senate NHS England |
| Mrs Katy Wheeler | Clinical Senate Administrator | West Midlands CN and Senate NHS England |
| Mrs Janet Smith-Morrison | Quality Improvement Officer | West Midlands CN and Senate NHS England |

# 4. Background

(Extract adapted from Next steps NHS Five Year Forward View 2017)

Each year the NHS provides around 110 million urgent same-day patient contacts. Around 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits. Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because it seems like the best or only option. The rising pressures on A&E services also stem from continued growth in levels of emergency admissions and from delayed transfers of care when patients are fit to leave hospital. In recent years the proportion of patients looked after within 4 hours has been falling – caused by rising demand in A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; the need to adopt good practice in hospitals consistently; and difficulties in discharging inpatients when they are ready to go home. Action now needs to be taken to improve services for patients and reduce pressure on our staff.

# 5. National Standards

The NHS Forward View states there will be:

Roll-out of standardised new 'Urgent Treatment Centres' which will open 12 hours a day, seven days a week, integrated with local urgent care services. They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine. Around 150 designated UTCs are anticipated , offering appointments that are bookable through 111 as well as GP referral, will be treating patients by Spring 2018.

National guidance for UCC's (Keogh 2015 and NHSE 2017) has stated to the effect that they should be co-located within Emergency Departments as part of an integrated urgent care service. There is also a new national service specification for the NHS 111 service, and this has been re-commissioned for the West Midlands (including Walsall) since November 2016 with major changes including an enhanced clinical hub with more callers receiving direct clinical advice, and booking appointments for callers within Urgent Treatment Centres as well as the GP Out of Hours Service.

## 5.1 Context

### 5.1.1 Walsall Urgent and Emergency Care System

Walsall CCG commission a range of services that make up the local urgent and emergency care system:

NHS 111
- 59 GP Practices
- Out of Hours GP Service (OOH)
- Urgent Care Centre – Town Centre (town centre UCC )
- Urgent Care Centre – Manor site (Manor site UCC)
- West Midlands Ambulance Service (WMAS)
- Accident and Emergency (A&E)
- Emergency Hospital Admissions.
- Crisis mental health services
- Adult Social care

Partners work together as part of the A&E Delivery Board to monitor performance of the urgent care system and to co-ordinate the development and implementation of plans to address areas of concern.

### 5.1.2 Urgent Care Centre Services

During 2014 the Walsall CCG undertook a review of urgent care services, including a full options appraisal and formal public consultation. In November 2014 the CCG Governing Body considered the outcome of the review and agreed:

- *The longer term plan should be for a single urgent and emergency care centre on the Manor Hospital site.*

- *As an interim plan, to relocate the walk in centre to a new town centre location and change the function of the service to an Urgent Care Centre (UCC), excluding from the specification activity that would normally fall within the scope of the national contract for GP services.*

In October 2015 Urgent Care Services (Urgent Care Centres and GP-Out-of-Hours service linked to NHS111) were reconfigured. Following an open procurement exercise, a five year contract was awarded to Primecare to provide an urgent care centre service, operating from two sites (see figure 1), and the GP Out-of-Hours (OOH) service (PEBC 2017):

Urgent Care Centre – town centre
- Open 8.00am to 8.00pm seven days a week – direct access for appointments

Urgent Care Centre – Manor site

- Open 7.00am to midnight seven days a week – direct access or streamed from A&E

GP Out-of-Hours (OOH) service

- Open from 6.30pm to 8.00am week-days and all of Saturday and Sunday – accessed via NHS 111 and providing phone advice; home visits; and face-to-face appointments at the UCC Manor site

<u>GP Extended Hours Winter Service (winter 17-18)</u>

The scheme provides GP and HCP appointments that can be booked via telephone from three hubs:

Hub 1 – Pinfold Health Centre, Bloxwich
Hub 2 – Broadway Medical Centre
Hub 3 – Darlaston Health Centre, Darlaston

Each hub provides evening and weekend appointments with a GP and HCA (ANP, nurse prescriber and/or nurse 6.30-9pm which have to be booked by a phone call. The telephone line for bookings opens at 8am)

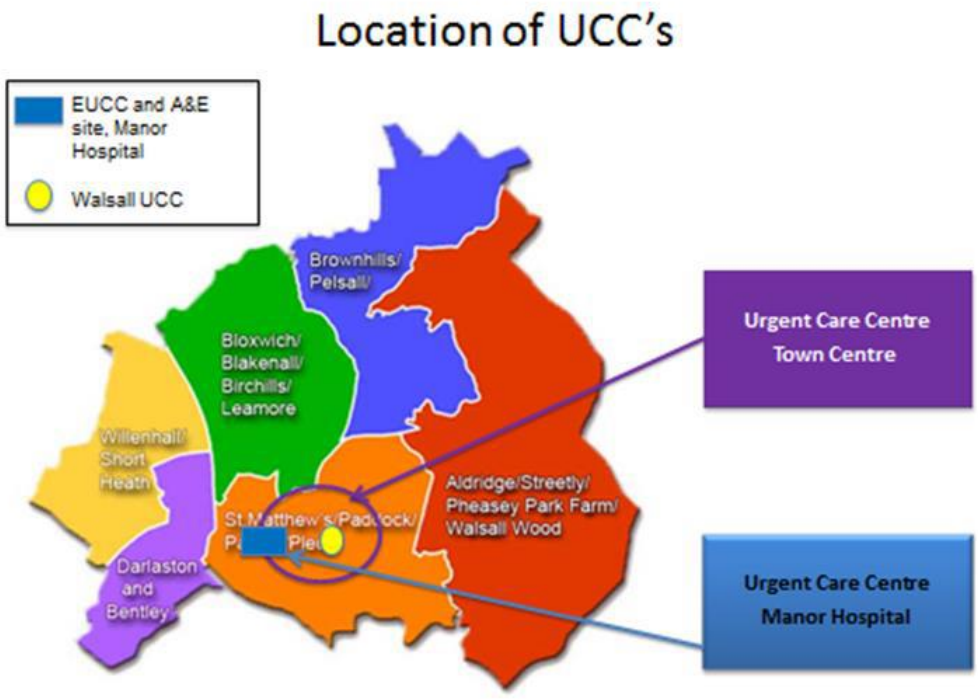


**Figure 1**

### 5.1.3 **Walsall UCC Challenges**

The summary below has been taken from the PEBC (2017):

- Demand for service in the UCC on the Manor site has increased compared to the previous service (by 7.3% Feb to April 2017), whilst demand at the UCC in the town centre has significantly reduced (by 23.4% Feb to April 2017).

- Demand for the GP Out of Hours Service is less than was planned and so there is spare capacity in this service that can be made available as an alternative for people who currently attend the UCC town centre, particularly between 6.30pm and 8.00pm week-days, and at week-ends.

- A majority of treatments could have been addressed via self-care, pharmacy, calling NHS 111, referral to the GP Out-of-Hours Service or by making an appointment with the patient's own GP.

- A significant amount of the footfall to the UCCs is from patients registered with town centre GP practices (i.e. circa 30% Hospital and 40% town centre).

- There is a clear relationship between proximity and ease of access to the UCCs and attendance, and this is more pronounced with the UCC (town centre). People living nearer to the UCCs are more likely to visit them.

- The main reason given by patients for attendance Monday to Friday was 'unable to have an appointment with own GP', with self-referral as the main reason at week-ends.

- Average monthly attendance at the UCC at the town centre has reduced since April/June 2016 and monthly attendance at the UCC at the Manor site has been comparatively stable.

- The level of acuity of people attending the UCC in the town centre is less than those attending the UCC at the Manor site

## 5.2 Case for Change

Extracts taken and adapted from PEBC (2017) and Walsall CCG Urgent Care Centre presentation (2017):

5.2.1 Walsall CCG's assessment of the current service at the town centre UCC was that activity levels have been lower than planned since it opened and that the majority of treatments could have been addressed via self-care, pharmacy, calling NHS 111, referral to the GP Out-of-Hours Service or by making an appointment with the patient's own GP.

5.2.2 Questions have been raised about the value for money of the town centre UCC if alternative services are already being funded to deliver services that could have met the needs of patients using the service.

5.2.3 The closure the town centre UCC would release funding that could be used:

a) To enhance the UCC service at the Manor and support A&E more effectively
b) To deliver cost savings to the CCG

5.2.4 The Benefits of Closing the Walsall Town Centre UCC:

a) Simplify access to urgent care services by locating the service on a single site
b) Enhance primary care streaming service with higher level of clinical decision making. This will contribute to meeting the specification for an Urgent Treatment Centre at the UCC Manor site.
c) Integrate primary care streaming with the ED triage process. This will contribute to the System Recovery Plan for meeting the A&E 4 hour standard.
d) Financial savings from reduced duplication of service

## 5.3 Guidance

The panel recognised that the model of care proposed is **aligned nationally**, as evidenced by the following documents:

a) High quality care for all now and for future generations: Transforming Urgent and Emergency Care Services in England (Revised November 2013)
b) Every One Counts; Planning for patients 2013-14 NHS England
c) Building the NHS of the Five Year Forward View, Business Plan 2015-2016 (2015) NHS England
d) The NHS Constitution, (2015) Department of Health
e) Keogh Report - Transforming urgent and emergency care services in England - Guidance for Commissioners regarding Urgent Care Centres (2015) UEC Review Team and Emergency Care Intensive Support Team (ECIST)
f) Urgent Treatment Centre – Principles and Standards (2017) NHS England
g) Urgent and Emergency Care, Next Steps on the Five Year Forward View (2017) NHS England
h) NHS Operational Planning and Contracting Guidance 2017 – 2019, (2016) NHS England and NHS Improvement
i) NHS Outcomes Framework for 2016 – 17 (2016) Department of Health

5.3.1 The panel recognised the model of care also **aligned to regional** directions and assessments coordinated by NHS England West Midlands, as evidenced by the:

a) UTC Standards designation and exceptions template v6 (2017) NHS England – West Midlands

5.3.2 **Aligned locally**, as evidenced by the:

a) Transforming Health and Wellbeing for all in Walsall. The Health and Wellbeing Strategy for Walsall 2013–2016, Refresh (2014) Health and Well Being Board Strategy
b) Walsall UCCs – Activity and Performance Monitoring Report – Nov 2017
c) Urgent Care Review - Outcome of Public Consultation on Future of Urgent Care Services – Walsall CCG Governing Body Public Meeting 2014
d) Integrated Urgent Care Services – Business Case for Public Engagement 2017 – Walsall CCG
e) Walsall A&E Board Recovery Plan 2017/18, A&E Board Operational Group on behalf of the Walsall A&E Board

## 6. Walsall Urgent Care Services review (preferred options)

At the Walsall CCG Governing Body meeting on 24th November 2014 *'The Governing Body gave approval of an urgent care centre hub (5 – 7 year plan) with an interim option of a town centre access centre to deliver urgent care.* Subsequent CCG discussions, have led to Option 2 (see below) becoming the emerging preferred interim option. Other options considered and discounted by the CCG are included in the table below.

| **Option** | **Rationale** |
|---|---|
| Option 1:<br>No change to current plan. | This would mean no change to the current service arrangements until the end of the 5 year contract, at which point the town centre service would close. |
| Option 2: (Preferred)<br>Close the UCC town centre service and enhance the service at the UCC Manor site. | This would mean that the UCC in the town centre would close, and some of the resource would transfer to increase capacity at the UCC (Manor site) as well as to enhance the primary care streaming process in the Emergency Department. The aim would be to add capacity to meet the additional demand at the UCC (Manor site), and to enhance the primary care streaming service in the Emergency Department with a higher level of clinical decision making. The higher level of clinical decision making in the streaming process would make it possible to achieve compliance with the new national service specification for an Urgent Treatment Centre. |
| Option 3:<br>Reduce opening hours at town centre UCC | Various options for partial closure of the UCC (town centre) have been examined in the context of reasons for attendance and variation in attendance levels at different times of the day or week. Partial opening options include evenings and week-ends only; week-ends only; or Monday to Friday in-hours service only. Another alternative would be for opening hours to be reduced to evenings only during week days and week-ends so that there is no overlap with day-time primary care services. |

# 7. Review and Recommendations

The review and recommendations are presented as per questions agreed within the terms of reference for the review. The independent Clinical Review Team identified some risks which Walsall CCG need to consider and have been reported below.

## 7.1 Question A: Provide a clinical opinion of the proposed provision of urgent care primary care services within Walsall

Key Findings

**7.1.1** The Walsall UCC town site was an interim plan put in place through the procurement of an UCC with a single provider through Primecare.

**7.1.2** From the evidence provided the panel was clear that the demand at UCC in the town centre has reduced and the level of acuity attending at the town UCC is less than those at the Walsall Manor Hospital site (PEBC 17). The majority of the treatments addressed at the UCC town site could have been addressed via self-care, pharmacy, NHS11, referral to GP out of hours or an appointment with their own GP (PEBC 17). The panel **agreed** that the case for change demonstrates a clear clinical evidence base for the closure of the Walsall UCC in the town centre. The panel was of the opinion that the current model of two UCC's in Walsall is unsustainable.

## 7.2 Question B: Consider the proposed consolidation of Urgent Care Services co-located on the Walsall Manor Hospital site

**7.2.1** KEY FINDING: The review of urgent care services in 2014 saw Walsall CCG develop a five year Urgent Care Strategy; one of its long term objectives was to have a single urgent and emergency care centre on the Walsall Manor Hospital site, and is dependent upon the completion of the Emergency Department (ED) redevelopment at the Walsall Manor Hospital site. There is no definitive start date for the redevelopment of the Emergency Department.

**7.2.2** The panel was in **agreement** with Walsall CCG that the closure of the town centre UCC before the end of the five year contract and transferring some of the resources to the UCC at the Walsall Manor Hospital site has the potential to realise benefits namely:

- Enhancing the UCC at the Walsall Manor Site
- Delivering cost savings to the CCG

**7.2.3** The panel identified a number of opportunities with the co-location of UCC service provision to improve the service model which Walsall CCG may wish to consider further. The following details the opportunities identified through key findings and recommendations are given:

**7.2.4** KEY FINDING: Currently the navigation (see definitions section 10) in the Emergency Department (ED) to the UCC is not a 24hr service, after midnight to 8am; it is dependent on the ED Staff liaising with Primecare staff.

**7.2.5** RECOMMENDATION: The panel was of the view that a more joined up and equitable service could be achieved through establishing joint protocols and ways of working. Streaming from the emergency department to the Walsall Manor Hospital UCC should be part of a 24hr, seven days a week service (see definitions section 10).

**7.2.6** KEY FINDING: Access to GP extended hours provision provided by the Hub is accessed by the patient via telephone to the provider; NHS 111, OOH services, and the UCC's are unable to refer directly to the service.

**7.2.7** RECOMMENDATION: Walsall CCG to work with GP Practices to sign a data sharing agreement providing consent to patient information by the provider.

**7.2.8** KEY FINDINGS: The panel was informed that the Extended Access to Primary Care through the formation of Hubs was established during the winter of 2017-18; the impact of the Hubs has not been fully evaluated.

**7.2.9** RECOMMENDATION: Walsall CCG to develop a robust mechanism to evaluate the Hubs informed by the aims and objectives of the service. The outcome of which should be used to inform urgent care primary services.

**7.2.10** RECOMMENDATION: Walsall CCG to consider how to influence patient behaviour and have an impact on cultural change, where patients are clear how to access primary care services, this should include clear signage on both UCC sites to direct patients and the public to the extended primary care hubs, Sensely App, self-care and pharmacy services.

**7.2.11** RECOMMENDATION: Where it is envisaged that behavioural change may be more challenging and less successful due to accessibility to the afore mentioned resources, the Senate has considered the health needs and outcomes of vulnerable patient groups such as homeless individuals and those from ethnic minorities as well as due consideration of population demographics in terms of current

utilisation of both urgent care centres. Assurance has been sought from Walsall CCG that specialised primary care provision for these patients has been considered and accounted for in terms of planning services and impact on General Practices serving central Walsall localities

**7.2.12** Key Finding: The panel was informed that access to an up to date electronic patient record was not was not possible as the GP practices used EMIS whilst the UCC used Lorenzo.

**7.2.13** RECOMMENDATION: The panel was of the opinion that the two systems are able to communicate and urgent negotiations should take place to look at a potential solution to resolve the situation.

**7.2.14** RECOMMENDATION: Walsall CCG should work towards a seamless urgent care pathway where referrals can be made directly into the Hubs.

**7.2.15** Key Finding: The panel received evidence that Walsall CCG carried out a public engagement exercise the 'Big Conversation' (2017) and a formal public consultation on the future of Urgent Care Services (HOSC 2017). The outcome showed that the majority of respondents wanted to keep the town centre UCC. The panel **commends** and **supports** Walsall CCG in holding a public consultation regarding services in its CCG area but must now respond to the publics concerns about losing the UCC town centre service.

**7.2.16** RECCOMENDATION: Walsall CCG should promote the benefits of a co-located UCC service on one site to patients and the public. This should include examples of best practice such as the availability of diagnostics and treatments (e.g. suturing, timely blood test results, the possibility of minor injuries and radiology provision). Multi – professional support with social care and mental health services on site, with the opportunity to develop further professional services such as interpreting and pharmacy.

**7.2.17** Key Finding: The panel noted the limited information supplied regarding staff engagement in the UCC's, Primecare and at the Emergency Department. The site visits provided a good opportunity for the panel to gain a deeper understanding of the challenges and issues within UCC primary care provision as perceived by staff.

**7.2.18** Key Finding: The current assumptions suggest 10% of patient flow will be redirected back into general practice once the town centre UCC closes. The panel is of the opinion that that this will have an impact on primary care services.

**7.2.19** RECOMMENDATION: Walsall CCG should consider the impact and additional capacity required on primary care services if the town centre UCC closes.

**7.2.20** RECOMMENDATION: More detailed work needs to be undertaken to ensure that the workforce in the ED and UCC at the Walsall Manor site; UCC town site and within primary care to ensure all are fully engaged and working together to deliver a seamless co-located service.

**7.2.21** KEY FINDING: The panel received evidence of the system wide Walsall A&E Board Recovery Plan (2017-18) which sets out a recovery plan for urgent and emergency care system in Walsall. The current system has continually failed to deliver the national standard for the four hour wait target. The plan focusses on improving the overall health and wellbeing of the people of Walsall and the outcomes of people using the urgent and emergency care services that serve them. The panel was **concerned** that no evidence was presented from WHT executive team with regards to the co-location of the UCC on the Walsall Manor Hospital site.

**7.2.22** RECOMMENDATION: Formal agreement and support is sought from WHT executive team with regards to the co-location of UCC on the Walsall Manor site. The facilitation of better integration between Walsall Manor Hospital ED and UCC.

## 7.3 Question C: Ensure proposals comply with national and local guidance and strategy

**7.3.1** Key Finding: The panel considered that the information and data presented **aligned with** the national direction of travel for Urgent Care Services (Keogh Report 2015 & UTC Principles and Standards NHSE 2014 & 17; Next Steps on the NHS Five Year Forward View 2017 and General Practice Forward View 2016.

**7.3.2** RECOMMENDATION: The panel was of the view that further work is needed to align national pharmacy initiatives to Walsall UCC service provision for example the minor ailments for children service.

**7.3.3** RECOMMENDATION: The panel was of the opinion that there will be an opportunity for Walsall CCG to provide an integrated urgent care service, aligning NHS111; urgent care treatment centres, GP out of hours and GP appointments.

## 7.4 Risks Identified

The panel was asked to identify the areas considered to be a potential risk and wish to highlight the following points to Walsall CCG with regards to the Walsall Manor site. These areas of risks are presented within the context that there is the potential that once the town centre UCC closes on the balance of probability there is likely to be an increase of patients attending the UCC at the already overstretched Emergency Department at the Walsall Manor Hospital Site.

**7.4.1** KEY FINDING: The area outside of the Emergency Department is the turning point for ambulances arriving and leaving the department. There are no pedestrian walkways and it is a hazard for the general public.

**7.4.2** KEY FINDING: The Emergency Department has a small waiting room and workspace with limited staff capacity -one triage nurse working. There is no definitive start date for the Emergency Department re-development. The UCC has already had to expand beyond its initial waiting area to an adjacent area outside of the main UCC, which is monitored by CCTV. There is no additional capacity to expand the UCC, should attendances further increase. An area identified that could be used if additional capacity is required is currently being used as a medical day unit.

**7.4.3** RECOMMENDATION: Walsall CCG and WHT develop UCC and Emergency Department contingency and mitigation plans for the risks identified above at the Walsall Manor Hospital site.

# 8. References


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- (HOSC 2017) Outcome of Consultation on the Future of UC Services

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- RCEM (2017) Royal College Emergency Medicine. http://www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

- Walsall CCG (2017) Walsall Health and Well Being Strategy http://www.walsallintelligence.org.uk/WI/navigation/home.asp

- Walsall CCG (2017) Presentation to the WM Clinical Senate July 2017

## 9. Glossary of Terms

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

A&E – Accident and Emergency

ANP – Advance Nurse Practitioner

CCG – Clinical Commissioning Group

CCTV – Close Circuit Television

ED – Emergency Department

EMIS - Egton Medical Information Systems

GP – General Practitioner

HCA – Healthcare Assistant

HEE – Health Education England

HOSC – Health Oversight and Scrutiny Committee

ICRT – Independent Clinical Review Team

IPEBC – Integrated Public Engagement Business Case

NHS – National Health Service

NHSE – National Health Service England

OOH – Out of Hours

PEBC – Public Engagement Business Case

ToR – Terms of Reference

UCC – Urgent Care Centre

UTC – Urgent Treatment Centre

WHT – Walsall Healthcare Trust

WMAS – West Midlands Ambulance Service

WMCS – West Midlands Clinical Senate

# 10. Definitions ED Navigation and Streaming

Navigation refers to the process of directing patients to appropriate services prior to a formal process of clinical assessment.

Simple Streaming is based on a clinical assessment alone. Good quality streaming will typically involve taking a brief history and performing basic observations. Streaming may be combined with triage, and calculation of an EWS for appropriate patients (RCEMM 2017)

Simple streaming will enable the streamer to direct the patient into the appropriate physical area of the department, in order to match the patient's needs to departmental capability. The process of triage, followed by streaming to majors or minors etc., represents the simplest form of streaming

## Streaming Standard

Streaming should be performed as soon as possible and ideally be within 15 minutes of the patient's arrival in the ED. For this to be achieved capacity must be planned to meet variation in demand, and not average demand RCEM (2017). Streaming is not about asking for permission (phone calls) it is about predetermined inclusion / exclusion criteria which both sender and receiver take responsibility / ownership for and design their service around this.

West Midlands Clinical Senate

## 11. Appendices:

### 11.1 Appendix 1 – Terms of Reference

# West Midlands Clinical Senate

*Walsall Urgent Care Review*
*Draft Terms of Reference*

First published: 22nd January 2018

**Prepared by**

**Angela Knight Jackson**
**Head of Clinical Senate**

# West Midlands Clinical Senate

## *Walsall Urgent Care Review*

## *Terms of Reference*

First published: 22nd January 2018

Prepared by

Angela Knight Jackson
Head of Clinical Senate
West Midlands Clinical Senate

# Document management

Revision history

| Version | Date | Summary of changes |
|---|---|---|
| v0.1 | 8.1.18 | First Draft TOR AKJ |
| V0.2 | 15.1.18 | Walsall amendments accepted |
| V0.3 | 22.1.18 | Sense Check amendments |
| | | |
| | | |
| | | |

Reviewers This document must be reviewed by the following people:

| | | | |
|---|---|---|---|
| Adrian Williams | Chair, Clinical Senate | 16th January 2018 | V0.2 |
| Walsall CCG | Chief Operating officer | 12th Jan 18 | V0.1 |
| NHS England WM DCO | Executive | 17th January 2018 | V0.2 |

## Related documents

| Title | Owner | Location |
|---|---|---|
| Clinical Senate Review Process Guidance Notes | NHS England | West Midlands Clinical Senate |

## Document control

The controlled copy of this document is maintained by the West Midlands Clinical Senate. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

West Midlands Clinical Senate

# TERMS OF REFERENCE

**Terms of Reference for:** Independent Clinical Review Panel

**Topic:** West Midlands Clinical Senate NHS England Stage 2 Review Walsall Urgent Care
**Sponsoring Organisations:** Walsall CCG
**Clinical Senate:** West Midlands Clinical Senate

**NHS England (Regional or DCO team):** West Midlands

**Terms of Reference agreed by:**

**Name**  **on behalf of the Clinical Senate**

**Prof Adrian Williams**

**Date:** 22/01/18

**Name**  **on behalf of the Sponsoring Organisations**

**Prof Simon Brake, Walsall CCG**

**Date: Received on** 24/01/18

**NB:** The following Terms of Reference have been developed using the document 'Clinical Senate Review Process Guidance Notes'. This document should therefore be read in conjunction with the document 'Clinical Senate Review Process Guidance Notes'.

## Independent Clinical Review Team Members

**Chair:**

| Name | Position | Organisation |
|---|---|---|
| Dr Masood Nazir | Chair Independent Clinical Review Team<br>GP<br>National Clinical Lead<br>Chief Clinical Information Officer & SRO<br>Clinical Information Lead and Senior Information Risk Owner | <br>Hall Green Health<br>Digital Transformation of General Practice NHS England<br>Your Care Connected programme<br>Birmingham CrossCity CCG Governing Body |

**Members:**

| Name | Position | Organisation |
|---|---|---|
| Prof. Adrian Williams | Vice Chair Independent clinical review Team<br>Chair Clinical Senate<br>Professor of Neurology | University Hospitals Birmingham NHS Foundation Trust |
| Dr Helen Carter | Deputy Director - Healthcare Public Health & Workforce | Public Health England |
| Dr Kamal Nathavitharana | Associate Postgraduate Dean | Health Education England |
| Mark Millins | Associate Director Paramedic Practice<br>Chair | Yorkshire Ambulance Service<br>NHS Ambulance Services Lead Paramedic Group |
| Dr Julian Povey | Chair | NHS Shropshire CCG |
| Dr John Oxtoby | Executive Medical Director | University Hospitals of North Midlands NHS Trust |

| | | |
|---|---|---|
| Dr James France | Consultant Emergency Medicine (A&E) | Worcestershire Royal Hospital |
| Mr Philip Toozs-Hobson | Consultant Gynaecologist | Birmingham Women's and Children's Hospital NHS Foundation Trust |
| Mr Peter Fahy | Director of Adult Services | Coventry City Council |
| Mr Jason Evans | Commissioning Manager for Urgent Care | Dudley CCG |
| Mrs Shilpi Rahman<br>Practice/ Manager<br>Business Partner (non-clinical) | Practice/ Manager | Marshall Street Surgery<br>Smethwick<br>West Midlands |
| Sneha Devlukia | Clinical Director | Health Inclusion Matters CIC |
| Satyan Kotecha | Pharmacist | NHS England<br>K&K Healthcare Ltd |
| Simon Radley | Consultant Surgeon, General & Colorectal Surgery | University Hospital Birmingham |
| Mrs Gillian Stewart | Patient Representative | N/A |
| Mr Peter Pinfield | Patient Representative | N/A |
| ***In attendance*** | | |
| Mrs Angela Knight Jackson | Head of Clinical Senate | West Midlands CN and Senate NHS England |
| Mrs Katy Wheeler | Clinical Senate Administrator | West Midlands CN and Senate NHS England |
| Mrs Janet Smith-Morrison | Quality Improvement Officer | West Midlands CN 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 2 report.

## Aim of the Independent Clinical Review

The Clinical Senate is asked to:

d) provide a clinical opinion of the proposed provision of urgent care primary care services within Walsall
e) consider the proposed consolidation of Urgent Care Services co-located on the Walsall Manor Hospital site
f) Ensure proposals comply with national and local guidance and strategy

**Scope of the review**

The scope of the review does not include a review of Walsall emergency care services and primary care services; however, the impact of the proposed consolidation of Urgent Care Services on the Walsall Manor Hospital site on emergency care and primary care services may be considered.

When reviewing the case for change and options appraisal the independent clinical review team (ICRT) should consider whether the preferred model delivers safe and effective care for 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). 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 ICRT should assess the strength of the evidence base of the case for change and proposed models.

## Timeline

The proposed timeline is subject to change. Changes to the timeline may originate from either the Sponsoring Organisation (SO) or Independent Clinical Review Team (ICRT). The ICRT may also take the decision to pause the review in order to gain more information and or expertise. All changes made to the timeline will be updated and circulated to both the SO, NHS England and ICRT by the Clinical Senate (CS).

| Week Beginning | Action | Organisation |
|---|---|---|
| July 2017 | Sponsoring Organisation (SO) formally requests clinical review of senate as part of NHS England's Stage 2 assurance | SO |
| Sept 17 | Senate council member appoints Chair | CS |
| November 17 | Recruitment of Independent Clinical Review Team panel members. | CS |
| 8.1.18 | Senate office and SO agree terms of reference (question, timeline and methodology) | CS |
| 11.12.17 | Senate Office request documentation from the sponsoring organisation | CS |

| | | |
|---|---|---|
| 8.1.18 | Conflict of Interest and confidentiality guidance to the Independent Clinical Review Team | CS |
| 8.1.18 | NHS England Sense Check TOR | CS |
| 8.1.18.1.18 | Documentation received from SO | CS |
| 15.1.18 | Documents and Clinical Senate process, governance and guidance dispatched to the independent clinical review team | CS |
| 15.1.18 | Independent Clinical Review Team reading | CS |
| 5.1.18 | Independent Clinical Review Team meet<br>Clinical review commences in line with TOR and methodology | CS |
| 22.1.18 | Day 1 of Independent Clinical Review Team | CS |
| 5.2.18 | Day 2 of Independent Clinical Review Team | CS |
| | Day 3 of Independent Clinical Review Team TBC | CS |
| 12.2.18<br>19.2.18 | Clinical Senate team Report writing | CS |
| 26.2.18 | Draft Report to Independent Clinical Review Team for input and amendments | |
| 5.3.18 | Report updated to incorporate amendments | CS |
| 12.3.18 | Draft Report to SO for fact checking (5 day Turnaround) | CS |
| 19.3.18 | Finalise report | CS |
| 26.3.18 | Sign off by Clinical Senate Council | CS |
| 2.4.18 | Formally submit final report to SO | CS |
| TBC | Publish and disseminate as per terms of reference | CS |

## Methodology

The role of the independent clinical review team will be to examine documentary evidence, carry out site visits if necessary and decide recommendations. The independent clinical review team may decide to increase or decrease the number of days required for review and also the method by which panel members provide input into the review.

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

- 24th January
- 8th February

The independent clinical review team will need to consider the following bullet points 5-9:

## 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 2 review (see as a guide Clinical Review Team Report Template appendix 3) to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report. The council may wish to take a view or offer advice on any issues highlighted that should be taken into consideration in implementing change.

The Council will be asked to comment specifically on the:

- Comprehensiveness and applicability of the review
- Content and clarity of the review and its suitability to the population in question
- Interpretation of the evidence available to support its recommendations
- Likely impact on patient groups affected by the reconfiguration
- Likely impact/ability of the health service to implement the recommendations

The final report will be submitted to the sponsoring organisation by week commencing 02.03. 2018 and the clinical advice will be considered as part of the NHS England's Stage 2 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 with the agreement of the sponsoring organisation.

## Communication and Media Handling

The Clinical Senate will ensure all communication activities, in whatever form, are conducted according to appropriate ethical, legal and professional standards, using professional guidance from in-house communications teams and or contracted external teams.

The Clinical Senate review will be published on the website of the Clinical Senate with the agreement of the Sponsoring Organisation. Council and assembly members will provide support to disseminate the review at a local level. The Clinical Senate may engage in various activities with the sponsoring organisation to increase public, patient and staff awareness of the review

## 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.

## 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.

## Functions, Responsibilities and Roles

### 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 2 formal service change assurance process.

## 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

## 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 2 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.

## 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, and 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.

## NHS England

NHS England will:

- Sense check the TOR to ensure that the review will deliver the views that address DCO concerns raised during the assurance process
- Requests to change the TOR should be made through the commissioner of the review

West Midlands Clinical Senate

## Appendices
## Appendix 1

# Declaration of Conflict of Interest

### West Midlands Clinical Senate
### Stage 2 Clinical Assurance Independent Clinical Review
### Walsall Urgent Care Review

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:

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.

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: _____

West Midlands Clinical Senate

## Appendix 2

**Confidentiality Agreement**
**West Midlands Clinical Senate Independent Clinical Review Team**
**Walsall Urgent Care Review**

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: Walsall Urgent Care Review

Signed _____ Date: _____

Name (caps) _____

## Appendix 3

**West Midlands Clinical Senate Independent Clinical Review Team Report Template**

**West Midlands Clinical Senate**
**Walsall Urgent Care Review**

[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

- [CLINICAL AREA]
- [Description of current service model]
- [Case for change]
- [Review methodology]
- Details of approach taken, review team members, documents used, sites visited, interviewees]
- [Scope and limitations of review]
- [Recommendations]

## CONCLUSIONS AND ADVICE

[References]

This should include advice against the test of 'a clear clinical evidence base' for the proposals and the other checks defined in the terms of reference agreed at the outset of the review.

Has the proposal been founded on robust clinical evidence? What evidence has been used and how has it been applied to local circumstances?

Has the available evidence been marshalled effectively and applied to the specifics of the proposed scheme?

## GLOSSARY OF TERMS

## APPENDICES:

Terms of Reference
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)

## 11.2 Appendix 2 – ICRT Panel Members' Biographies

| Name | Dr Masood Nazir<br>MB ChB MRCGP MSc (Medical Leadership) DCH |
|---|---|

Qualifying as a doctor in 1997 I moved into general practice in 2001. As a GP in Birmingham with over 15 years of experience my passion is improving services for patients while making it easier for colleagues to deliver healthcare.

As the National Clinical Lead for the Digital Transformation of General Practice, I have been instrumental in introducing new ways of empowering and communicating with patients. Putting patients at the heart of service change remains a priority, as well as influencing new ways of working; improving efficiency and upholding quality.

At a local level, as a member of the CCG Governing Body, I hold the following positions; Chief Clinical Information Officer, Senior Information Risk Owner for the fourth largest CCG in the country and Senior Responsible Officer for a local record sharing programme bringing together 18 organisations and a registered population of 1.8 million patients.

Ultimately, making positive change requires delivering and communicating a demonstrable result. It is this determination and commitment to patient improvements and clinical collaboration across all organisations, which saw me awarded the prestigious accolade of CCIO of the Year 2016/17

| Name | Professor Adrian Williams |
|---|---|

Adrian Williams graduated from University College Hospital, London and, after training in General Medicine there, took up a lectureship at The Cardiothoracic Institute, Brompton Hospital, investigating the pulmonary changes associated with chronic liver disease.

In 1975 Dr Williams was recruited to Harvard Medical School, Boston where his interest in sleep began with the investigation of Sudden Infant Death Syndrome (S.I.D.S.) and publication of a definitive study implicating obstructive sleep apnoea (OSA) as one cause of this syndrome.

An invitation to the University of California at Los Angeles in 1977 to take up a post as Chest Physician allowed this early interest in OSA in infants to extend into adult patients with the very first reports of OSA causing hypertension, and of oximetry as a natural diagnostic tool. In 1985 Dr Williams became tenured Professor of Medicine at UCLA and co-director of the UCLA Sleep Laboratory.

As Sleep Medicine gelled as a specialty, Dr Williams was one of the first to take the

Board exams in 1989 to become an accredited polysomnographer and later member of the American Academy of Sleep Medicine.
In 1994 Dr Williams returned to London where he established the Sleep Disorders Centre at St. Thomas' Hospital.

He has published extensively on Sleep Disorders including more than 100 peer reviewed original scientific papers and more than 80 other published papers including chapters and books.

Dr Williams is a Diplomat of the American Board of Sleep Medicine, a founding member of The British Sleep Foundation, the Sleep Medicine Section of the Royal Society of Medicine as well as the RLS UK Group, and was recently appointed Professor of Sleep Medicine, King's College London.

Dr Williams is Professor of Clinical Neurology at the Regional Centre for Neurology at the Queen Elizabeth Hospital Birmingham. He is also a senior advisor to the Parkinson's Society and Chair of the West Midlands Clinical Senate.

| **Name** | **Dr Helen Carter** |
|---|---|

Helen is a Birmingham University Medical graduate who started working in the field of Public Health in 2001. She has worked for many different organisations during this time including Health Authorities, Primary Care Trusts, and Strategic Health Authority on a wide range of projects and programs.

Helen joined Public Health England when it was formed in 2013. Her portfolio is currently very diverse and includes being the PHE Children and Young People Executive Team sponsor and the Vice chair of the West Midlands Clinical Senate.

| **Name** | **Dr Kamal Nathavitharana** |
|---|---|

Kamal is Associate Postgraduate Dean, Quality, Research and Innovation, Health Education England - West Midlands. He is a Consultant Paediatrician and Gastroenterologist, Honorary Associate Professor at Warwick Medical School and Honorary Senior Lecturer at the Birmingham Medical School.

Kamal is a strong advocate for paediatrics and is a published researcher in mucosal immunology and medical education. He is a passionate enthusiast for education and training, leading the development of the online generic induction through a multi-professional partnership across the West Midlands region.

| Name | Mark Millins |
|---|---|
| Mark Millins is an Associate Director Paramedic Practice for Yorkshire Ambulance Service and Chair of the NHS Ambulance Services Lead Paramedic Group. He is a former member of the College of Paramedics Consultant Paramedic Group and was on the editorial team for the 2013 and 2016 versions of the UK Ambulance Services JRCLAC Clinical Practice Guidelines and member of the Yorkshire and Humber Clinical Senate. | |

| Name | Dr Julian Povey |
|---|---|
| Julian qualified in 1991 from St. Bartholomew's Hospital London. He has been a GP since 1996 and has held various roles involved in GP Education. Since 2009 he has been involved in commissioning healthcare and since 2015 has been the GP lead and then the Chair of NHS Shropshire CCG. Julian has been a GP partner in rural Shropshire since 1997.<br><br>He has been involved in wide range of service re-design processes and been part of multi-commissioner and regional procurements.<br><br>He is keen to ensure that service re-design works for all parties with patients at the centre, but ensuring views of staff, providers, commissioners and regulators are listened to and acted on appropriately. | |

| Name | Dr John Oxtoby |
|---|---|
| Dr Oxtoby is a Consultant Radiologist. His areas of clinical practice are nuclear medicine diagnosis, general radiology, vascular ultrasound and thyroid imaging. Dr Oxtoby has significant medical management duties. In addition to his current role of Acting Executive Medical Director, he is also Caldicott Guardian for the Trust.<br><br>After qualifying from Edinburgh University in 1984 Dr Oxtoby undertook broad-based medical training in the UK and New Zealand between 1984 and 1990. Subsequently he trained in radiology and was appointed as consultant in Radiology and Nuclear Medicine at UHNM in 1996.<br><br>Dr Oxtoby is proud to work at University Hospitals of North Midlands and relishes the challenges involved in working as a medical director. He is passionate about developing our hospitals to ensure we are able to provide the best possible medical care. | |

| Name | Dr James France |
|---|---|
| James France is a Clinical Lead Emergency Medicine (A&E) Worcestershire Royal Hospital, member of the RCEM Quality and Effectiveness Committee (Best Practise) and RCEM Examiner. | |

| Name | Philip Toozs-Hobson |
|---|---|
| Philip Toozs-Hobson is a Consultant Urogynaecologist working at Birmingham Women's and Children's NHS foundation trust.<br><br>He has experience as CD for Gynaecology for 4 years 2011-15. He has also served on the British Society of Urogynaecology executive for 3 years.<br><br>Philip was on the NHSE working party on vaginal mesh and tapes and has previously sat on the Senate panel reviewing services<br><br>He is active in research and passionate about patient outcome measures and performance assessment. | |

| Name | Peter Fahy |
|---|---|
| Peter Fahy is the Director of Adult Services for Coventry City Council, a role he took up in October 2015. He has been in local government since 1997 and social care since 2003 in which has managed a range of service areas including Adults Safeguarding, Housing, Provider Services and Commissioning across children's and adult's services.<br><br>External to the City Council Peter is national policy lead for ADASS (Association of Directors of Adult Social Services) for Physical and Sensory Impairment and West Midlands lead Use of Resources. | |

| Name | Jason Evans |
|---|---|
| As Commissioning Manager for Urgent Care for Dudley CCG Jason's senior role necessitates a comprehensive grasp of whole system urgent and emergency care performance, commissioning, service redesign and project management. He has a budget portfolio of approximately £90 million and hold to account key providers within the urgent care system, including Dudley Group NHS Foundation Trust for unplanned care, the Urgent Care Centre provider and via CCG alliance agreements the Integrated Urgent Care Service and West Midlands Ambulance Service. | |

| Name | Shilpi Rahman |
|---|---|

Shilpi Rahman has been working in NHS-Primary Care since 1989 at her own General Practice where by her role at **Marshall Street Surgery**, is a Non-Clinical Partner-**Practice & Business Manager**. The area which this practice falls is deprived area in 5% in UK.
This has provided Shilpi with insight to true capture of reality for the last 29-years. Shilpi's **"passion"** NHS and General Practice.
2014-head-hunted by CQC to conduct the New Regulations to Inspect GP-surgeries.
To date **2015-2017** Shilpi has inspected as a **SpA-Practice Manager,** 150-Inspections through-out UK. (Not Sandwell or Birmingham, due to Conflict of interests.)

Shilpi, also from 2014 has been involved with the formation of **Aston Medical School**. From Dec 2017-18. She is now a MMI-Assessor who has conducted 4-days, intense MMI-interviews recruits Sept-2018. Marshall Street Surgery is one of the Training Practices who will assisting with these new future doctors.

Sandwell CCG-formation September 2013- Shilpi is Chair for Shac- LCG Practice Managers.

2014-2016- CQRS- Primary Care Chair. For NSHE and GP – Payments scheme i.e. Qof, PCCF…..

Worked with PCT for Qof- Inspections and assisted CCG with New-initiatives pieces of work

2014-2016- Assisted and was voted by LCG to form Sandwell Doctors Federation.

Latest : News 15/3/18 – Chosen to be chair for 1-of the Sandwell working groups Lead, for NHS-5 Years Forward View. Really looking forward to sharing my ideas and working with "like minded people"

| Name | Dr Sneha Devlukia |
|---|---|

Dr Sneha Devlukia is Clinical Director of an Inclusion Health Service that provides core primary healthcare to specifically target the needs of homeless and socially disadvantaged individuals within the UK.

She continues her clinical practice within this area working as a GP.

Having trained and practiced in the West Midlands area over the last twenty years, Sneha holds specialist interests in mental wellbeing, social determinants of health inequalities and the advocacy of marginalised groups within NHS service delivery and sustainability planning.

| Name | Satyan Kotecha |
|---|---|
| Satyan, an experienced Community Pharmacist for over 20 years, presently Superintendent Pharmacist of K & K Healthcare Ltd. Satyan has previously worked as PEC (Professional Executive Committee) Pharmacist for Leicester City PCT, he currently serves on LLR and Warwickshire Local Pharmaceutical Committees. Arden Hereford Worcester LPN Chair December 2013 – November 2015 and now covers the West Midlands NHS geography. Satyan is the LPC representative on Arden Area Prescribing Committee & Respiratory sub-group, and he is also a member of West Midland Diabetes Clinical Network. | |

| Name | Simon Radley |
|---|---|
| Simon Radley qualified from Birmingham University in 1985. He is a Consultant Surgeon, General and Colorectal Surgery and he is currently the West Midlands chapter representative and is a council member of the Association of Coloproctology of Great Britain & Ireland. | |

| Name | Peter Pinfield |
|---|---|
| Peter is the Chairman of Healthwatch Worcestershire and has been involved both publically and strategically in Worcestershire's Health and Social Care for 35 years. He has previously been joint leader of the County Council, Chairman of the County's Social Services Committee, Champion for Older People's Services, Chairman of Health Scrutiny and a Non-Executive Director of NHS Worcestershire PCT where he led on patient engagement<br><br>He is also a Mental Health Associate Manager**.** | |

| Name | Gillian Stewart |
|---|---|
| Following more than three decades in the NHS as a nurse and senior manager, Gillian retired and now volunteers as the Chair with Healthwatch Telford and Wrekin and independent consumer champion for health and social care.<br><br>She possesses excellent interpersonal, communication and negotiation skills and has the ability to develop mutually beneficial relationships with key stakeholders.<br><br>Currently Gillian provides leadership and strategic direction to the Managing Director to ensure services commissioned and provided in Telford and Wrekin borough are the best they can be, with evidence that patients and the public are at the centre of service delivery. | |

## 11.3 Appendix 3 – Agendas – Day 1 and 2

### 11.3.1 Day 1

**Agenda Day 1**

**Independent Clinical Review Panel**
**Stage II Clinical Assurance of Walsall UCC Services Review**
**Wednesday 24th January 2018, 9:00 until 16:30**
**Venue – Park Regis, Birmingham, 160 Broad St, Birmingham B15 1DT**

**AGENDA**

| Item | | | Purpose |
|---|---|---|---|
| 09:00 | | Arrival with Refreshments<br>Panel Pre-meet Masood Nazir & Clinical Senate Team | |
| 09:30 | 1 | Session 1:<br>Introduction and Review of Documentation Submitted | Introductions<br>Housekeeping<br>Declaration of Interest<br>Review ToR<br>Overview of the documentation |
| 11:00 | | Refreshments | |
| 11:15-12:15 | 2 | Panel Discussion – Key Lines of Enquiry | Explore and clarify specific issues<br>Formulate questions for Commissioners |
| 12.15 -13.00 | 3 | Session 2:<br>Presentation from Sponsoring Organisation | Commissioners presentation of the Clinical Case for Change and preferred Clinical Model |
| 13:00 | | Lunch and Refreshments | |
| 13:30 14.30 | 4 | Panel Questions to Commissioning Organisation | |
| 14:30 15.00 | 5 | Panel Deliberations | Assess, Agree and Capture |
| 15:15 | | Refreshments | |
| 15.15 -16.00 | 6 | Panel Deliberations | Assess, Agree and Capture |
| 16:15 | 7 | ICRT Chair - Debrief with Sponsoring Organisation | Debrief |
| 16:30 | | END | |

**11.3.2 Day 2 – Site Visit**

# Agenda Day 2

**Independent Clinical Review Panel**

**Stage II Clinical Assurance of Walsall UCC Services Review**

**Thursday 8th February 2018, 9:00 until 12.00**

**Venue(s) –**
**Morning Session – Walsall Urgent Care Centre, Saddlers Shopping Centre, Bridgeman Street, Walsall WS1 1YT**
**Followed by Walsall Manor Hospital, Moat Road, Walsall WS2 9PS**

**In Attendance: James France, Gillian Stewart, Shilpi Rahman, Masood Nazir, Angela Knight Jackson**

**AGENDA for Site Visits**

| Item | | | Purpose |
|---|---|---|---|
| 09:30 | 1 | Session 1:<br>Arrival at Walsall & Tour of UCC | Site Visit |
| 10.00 | 2 | Walk to Walsall Manor Hospital UCC | |
| 10.20 | 3 | Walsall Manor Hospital UCC site visit | Site Visit |
| 10.50-11.50 | 4 | Session 2:<br>Dr Asghar Walsall CCG; Dr Shah Primecare; Miss Joshi Clinical Director for A&E and Dr Najum Rashid (tbc) WHT at Walsall Manor Hospital | Meeting and Refreshments |
| 11.50 | 5 | Journey to Park Regis, Birmingham | Taxi from Walsall to Birmingham |

### 11.3.3 Day 2 – Documentation Review

## Agenda Day 2

**Independent Clinical Review Panel**
**Stage II Clinical Assurance of Walsall UCC Services Review**
**Thursday 8th February 2018, 9:00 until 16:45**
**Venue – Park Regis, Birmingham, 160 Broad St, Birmingham B15 1DT**
**AGENDA for Documentation Review**

| Item | | | Purpose |
|---|---|---|---|
| 09.00 | | Arrival with Refreshments | |
| 09.30 | 1 | Session 1:<br>Introduction<br>Review of Day One | Introductions<br>Housekeeping<br>Declaration of Interest<br>Review ToR<br>Overview of the documentation |
| 10.30-11.00 | 2 | Session 2:<br>Review of Additional Documentation submitted | Explore and clarify specific issues |
| 11.00 | 3 | Refreshments | |
| 11.15-12.30 | 2 | Session 3:<br>Review of Additional Documentation submitted<br>Panel Discussion – Key Lines of Enquiry | Explore and clarify specific issues<br>Formulate questions for Commissioners |
| 12.30 | 3 | Lunch and Refreshments | |
| 13.00-14.30 | 4 | Session 4:<br>Feedback – Site Visits and Review of Additional Documentation<br>Panel Discussion – Key Lines of Enquiry | Formulate questions for Commissioners |
| 14.30-15.00 | 5 | Panel Questions to Commissioning Organisation | Assess, Agree and Capture |
| 15.15 | 6 | Refreshments | |
| 15.15-16.00 | 7 | Session 5:<br>Panel Deliberations | Assess, Agree and Capture |
| 16.00-16.20 | 8 | Summary | |
| 16.20-16.45 | 9 | ICRT Chair - Debrief with Sponsoring Organisation | Debrief |
| 16.45 | 10 | END | |

## 11.4 Appendix 4 – List of Evidences

| | |
|---|---|
| 1. | Integrated Urgent Care Services – Business Case for Public Engagement 28 June 2017 – Walsall CCG |
| 2. | Urgent Care Review - Outcome of Public Consultation on Future of Urgent Care Services – Walsall CCG Governing Body Public Meeting 27 Nov 2014 |
| 3. | Walsall UCCs – Activity and Performance Monitoring Report – Nov 2017 |
| 4. | Overview Scrutiny Committee – OUTCOME OF ENGAGEMENT ON THE FUTURE OF URGENT CARE SERVICES - November 2017 |
| 5. | UCC Performance Reporting Schedule – Walsall CCG Contract ref: 05Y-CT-15-YO0771-024 |
| 6. | Primecare Quarterly Quality Report - Qtr 2 2017/18 |
| 7. | *Keogh Report - Transforming urgent and emergency care services in England - Guidance for Commissioners regarding Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services (Website Ref)* |
| 8. | NHS Outcomes Framework (Website Ref) |
| 9. | NHS Constitution (Website Ref) |
| 10. | Walsall Health and Well Being Strategy (Website Ref) |
| 11. | CCG Service Specification - GP Extended Hours Winter Service 2017-18 |
| 12. | Walsall A&E Delivery Board System Recovery Plan September 2017 |

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