NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Sarah Halstead
Senior Service Specialist
Specialised Commissioning (Yorkshire & Humber)

Via email

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28th November 2019

Dear Sarah

Senate Review of Proposals for Mechanical Thrombectomy in Acute Stroke

Thank you for the opportunity to review your future model for mechanical thrombectomy services in Yorkshire and the Humber.

The objectives of this review are for the Senate to provide you with independent clinical oversight of the proposed clinical model to assist in its further development. Our advice will be used by specialised commissioners to develop appropriate plans with key stakeholders to enable a mechanical thrombectomy service to be extended to include weekend availability. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion during October and November 2019 are listed within the Terms of Reference enclosed with this letter. Many thanks to Graham Venables, Clinical Director for Clinical Networks and Specialised Commissioning Clinical Lead for this proposal, for joining the November calls which improved our understanding of the proposals.

Your Proposal

Currently Mechanical Thrombectomy (MT) is carried out in the interventional neuroradiology suites at Hull (serving the Hyper Acute Stroke Units (HASUs) in Hull, Scunthorpe and York), Leeds (serving HASUs in Leeds, Bradford, Mid Yorkshire and Calderdale) and Sheffield (serving HASUs in Sheffield, Doncaster and Chesterfield). Each operates on patients presenting in their catchment area with patients being accepted between 08:00 and 15:00 hours Monday to Friday. At present, there is no in-hours service on Saturday and Sunday and no referrals are accepted after 15:00hrs to allow out of hours access to interventional neuroradiology for existing commitments, including emergency neurosurgical and trauma cases. This disadvantages 60 – 70% of those with stroke who would be eligible for the procedure but present with symptoms when the MT service is not available. Your proposal is that as an interim measure, whilst the workforce expands, you will offer MT at a single centre for all referrals from the HASUs in Yorkshire and the Humber and Chesterfield on a one in three rotating basis between the 3 treatment centres in Hull, Sheffield and Leeds.

It is anticipated that weekend working could commence in the summer of 2020 when there are three operators in each MT centre.

At present, there are 7 Interventional Neuro Radiologists (INRs) in Yorkshire (3 Leeds, 2 Sheffield, 2 in Hull). To date, an Interventional Vascular Radiologist (IVR) has been upskilled and credentialled in Hull and there are two further Interventional Vascular Radiologists being upskilled at present. A Neuroradiology National Training Number (NTN) holder is coming to the end of training in 2020 and it is anticipated that they will be recruited within the region and shortly there will be two neuroradiology fellows in training. It is expected to take 5 years before each of the 3 units has built its workforce to deliver their own 7-day service.

The question that you asked us to consider is:

- Is a regional Mechanical Thrombectomy (MT) service, delivered by each of the three MT centres (Hull, Leeds & Sheffield) on a one in three rotational basis, a suitable and acceptable interim solution to enable a MT service to be available during weekend days?

Summary

We very much welcome your proposals to try to increase the number of hours in which you can provide this life changing intervention and we congratulate the Yorkshire and the Humber clinicians in trying to seek a solution during the years in which it will take for the workforce to grow. The panel agrees that this interim solution is a very positive step forward and we wish to see this service expand whilst each centre develops its workforce to offer its own 7-day MT service. Advice from Health Education England is that there is a General Medical Council (GMC) credentialing pilot to train other clinicians (neurosurgeons, stroke physicians, neurologists, for example) to deliver this technique in a shorter time frame of 2 – 3 years. The workforce implications for growing this service therefore, may not be as severe as the 5-year timeline you are anticipating. Whilst the panel is supportive of proposals that will safely deliver MT to more patients, we advise that there are significant challenges with the proposed model. The proposals need further consideration on 4 main issues before we can endorse this as a suitable and acceptable interim solution. These are: -

1. To consider whether a single centre should be the focus for the weekend service and operators from the other sites travel to provide cover rather than trying to rotate the site covering the region.
2. To further explore the possibility of extended weekday working in parallel to weekend hours.
3. To simplify the communications between referral units and referring centres and ensure there is a solution to the issue of the image transfer.
4. To address the need for comprehensive audit and joint governance.

Once these are addressed the Senate can provide its full support to this interim model.

I hope this letter provides a constructive summary of our comments and advice.

Key Recommendations

1. To consider whether a single centre should be the focus for the weekend service and operators from the other sites travel to provide cover rather than trying to rotate the site covering the region.

2. To further explore the possibility of extended weekday working in parallel to weekend hours.

3. To consider how aneurysm coiling for subarachnoid haemorrhage can be delivered alongside thrombectomy in this model.

4. To simplify the communications between referring unit and referral centre and to consider a single point of contact.

5. To further consider if your proposal for the review of Computed Tomography Angiography CTA scans is a sustainable long-term solution.

6. To prioritise investment in solutions to imaging transfer.

7. To confirm the ambulance protocol within the documentation**.**

8. To reflect greater flexibility about the possibility of relatives travelling in the ambulance.

9. To establish a comprehensive auditing system for MT which captures the whole pathway from the point of query through to surgical outcomes with joint governance in place.

10. To establish a process to gather information from patients, families and carers with a view to improving the patient experience.

Senate Comments and Advice

Clinical Evidence Base

The Senate notes the supporting evidence that you provided, particularly the "Mechanical thrombectomy for acute ischaemic stroke; an implementation guide for the UK" edited by Professors Gary Ford, Martin James and Phil White and we agree that your proposals are in line with national guidance.

Activity Modelling

We understand that each of the three centres is a neurology / neurosurgery centre commissioned by NHSE&I and expected to provide MT for the area served. One of the questions we explored with you in conversation was whether the modelling supported the need for a rota of 3 centres in this interim proposal.

Your modelling anticipates that the weekend hours will mean that 50 more people can be treated in the first year and 25 – 50 will be assessed as not suitable on arrival at the MT centre. This equates to approximately 1 – 2 patients per weekend. You also assume a 30% in year increase as clinicians became more familiar with the service. Based on those figures you do not need 3 centres for weekend working at this point in time. We recognise however, that you need to build the service to be able to offer MT to all eligible patients. With stroke figures across Yorkshire and the Humber totalling approximately 9200 per year you need to plan for a service that can provide MT for approximately 10% -12% of these patients. Current modelling suggests that Leeds will provide half of those procedures and approximately a quarter each in Hull and Sheffield. We therefore agree with the proposed 3 centre model and acknowledge that if you centralise the weekend activity further, in the interim you risk limiting the potential for the other 2 centres to develop and in time causing significant capacity issues to the centre.

The interim 1 in 3 model, however, does provide significant challenges. The travel information shows that for much of the Yorkshire and the Humber population, Hull is difficult to get to with significant increased journey time. You have recognised this but have felt that it is necessary to reduce the pressure on the other 2 sites longer term. We advise however, that with significant journey times more needs to be done to ensure that there are no unnecessary delays in the patient pathway. Our advice on these points is particularly in relation to the imaging, communications, decision making between the unit and the centre, and the ambulance service availability. These are detailed in the relevant sections below.

Based on their experience, our panel advise that with the long travel times combined with potential delays due to challenges in the scanning infrastructure, there will be a number of patients who will require re-imaging at the referral centre. This has not been considered within your proposals. The panel also wishes you to consider that, due to the issues highlighted, there will be a proportion of patients who will fall outside of the acceptable time window for treatment. This leads us to question whether you have overestimated the anticipated numbers for weekend activity and therefore to also question whether this model achieves the right balance between the increased activity and the commitment and resources required, compared to alternative models to expand the service.

We understand that each of the 3 providers are considering the impact of these MT proposals and are expected to provide a gap analysis within the next few weeks. We are concerned that it will be difficult to get the resources required for a service that you only need every 1 in 3 weekends. There will be fluctuating requirements for stroke team, interventional teams and bed capacity. You may also have underestimated the challenges in simultaneously implementing this weekend model in 3 centres and turning on and off the different levels of staffing and availability. We advise that this is considered further in the future planning.

The challenges in transfer distances and the complexities of a 1 in 3 rota weekend model led the panel to consider whether you had adequately considered and decided against the alternative proposal to have a region wide rota with a combined on call team which drives to the designated centre. We recognise that there are risks with MT operators undertaking a complex procedure in unfamiliar surroundings but this is a manageable risk and the team does become more familiar very quickly. This is an alternative you may wish to ensure you have adequately explored before deciding on your preferred model.

Recommendation: *To consider whether a single centre should be the focus for the weekend service and operators from the other sites travel to provide cover rather than trying to rotate the site covering the region.*

Extension of Weekday Hours

We discussed with you your decision to extend weekday hours as the phase 2 of the expansion in service rather than making this the first step. The reason you have not opted for this first is the existing pressure on other elective and emergency neuroscience services in the early to mid-evening, whereas over the weekend there is little or no elective work. We recognise this issue and you will need to make the judgement on what is achievable but whilst this may be perceived as difficult, it is also the time when the hospital is better staffed and therefore more capable of responding to emergencies. Our advice is to further explore the possibility of extended weekday working in parallel to the weekend hours as, based on the experience of the panel, this is considered to be an easier mechanism to increase the number of patients treated. The advantage of this is in improving the skills of the team and embedding the MT service across your referring networks, moving away from an ad hoc on/ off system, which limits the expectation of referrers that thrombectomy is available.

Recommendation: *To further explore the possibility of extended weekday working in parallel to weekend hours.*

Utilising the Skills of the MT Team

Our panel questioned whether you had considered how coiling for the treatment of subarachnoid haemorrhage is integrated into a stroke thrombectomy service that rotates between three sites. We understand that you have had limited discussions about this but decisions about a region wide neurovascular service have been deferred pending advice from national teams. You acknowledge that you do need to be part of the discussions to ensure that you look at the opportunities to maximise the resource of the MT team.

Recommendation: *To consider how aneurysm coiling for subarachnoid haemorrhage can be delivered alongside thrombectomy in this model.*

Streamlining the Patient Pathway

Clarity of communications and decision making in the referral process are key in mitigating the risks of the increased travel time and we are not convinced that they are as streamlined as they could be. You will also have to consider that if there is significant time between the initial scans and the patient's arrival at the referring centre then that centre will need to reassess the patient and repeat the investigations. This will delay the procedure and edge some patients beyond the 6-hour window. With some long travel times you have a very tight timeline to provide treatment and our advice on reading the Standard Operating Procedures (SOP) is that there is room here to simplify and streamline the referral pathway.

The process of communication between the referral unit and the centre reads as unnecessarily complex with steps in the process from the nurse, to the stroke consultant to the Interventional Neuro Radiologist (INR), with individual roles unclear within that. The communication and referral processes need to be considered from the point of view of a referring clinician. The Senate was pleased to learn that in each of the HASUs there is a senior clinical decision maker on site from 8 am to 8pm and that this has resulted in a reduction to door to needle times. We advise that you simplify the pathway to ensure the stroke consultant in the referral unit can have a telephone discussion with the consultant in the referral centre. You may wish to consider a single point of contact to simplify the communications. At present, the processes are written from the point of view of each centre independently and referrers cannot be expected to hold onto different mechanisms of referral depending on the day of the week.

We also suggest that you re-look at the flow chart on page 3 of the SOP. We support having a standardised protocol which is applicable to all 3 units but accommodating the differences has resulted in an unnecessarily complicated document and we advise that more work is done to simplify this into a common view.

Recommendation: *To simplify the communications between referring unit and referral centre and to consider a single point of contact.*

On discussion, you have confirmed that at present <18 year olds are not included in the service specification, however each of the centres would be happy to treat these on a case by case basis (and has done so in the past). We advise that there should be a line in your procedures to reflect this.

Imaging

You have confirmed that each admitting hospital has the capability to undertake a Computed Tomography Angiography (CTA) which is essential in determining if patients are eligible for MT. These are available 24/7 365 days a year. The panel was pleased to learn that every

site is capable of this as in their experience, centres struggle with CTA. The panel raised concerns about who has the skills to interpret those scans but you have confirmed that the INR or IVR will review the CTA in the referral centre. This is a welcome solution which addresses this issue and we advise that this is clearly stated in your documentation. The panel, however, is concerned that this answer suggests that all CT head and CT angiography examinations for acute stroke within the region will be reviewed by the INR. This is potentially a very onerous offering for such a large region as the risk is that referring sites will quickly absolve themselves from reviewing these scans.

Recommendation: *To further consider if your proposal for the review of CTA scans is a sustainable long-term solution.*

The most worrying limiting factor in your proposals is the inability for all sites to transfer a direct image of the CTA scans to allow MT teams to be organized ahead of the patient's arrival on-site. Currently you do not have a system wide solution to this across Yorkshire and the Humber. In Humber Coast and Vale there is easy access to all images at referring providers but in West Yorkshire and South Yorkshire and Bassetlaw images need to be pushed through the existing Image Exchange Portal and this can be slow. Although the patient will still be transferred if images are in transit, it is not acceptable to continue on this basis. You need an image transfer solution to allow your proposed model to work effectively. We understand that there are active discussions underway and you are attempting to establish a priority mechanism that will ensure swift transfer of images. We welcome that you are looking into IT solutions including Rapid and our panel also discussed other alternatives like 3DNet by Biotronics, a cloud-based PACS with experience in supporting stroke networks. There needs to be agreement as to the best solution at regional level for Yorkshire and the Humber and investment prioritised for this.

Recommendation: *To prioritise investment in solutions to imaging transfer.*

Transport

The table on page 10 of your proposal contains some inaccuracies (including the inclusion of Halifax Infirmary as well as Calderdale Royal Hospital and some questionable excess transfer times) and this needs to be revised to accurately reflect the impact of these proposals.

Transfer between the referring unit and the referral centre must happen without delay. We understand that you have had excellent co-operation from Yorkshire Ambulance Service NHS Trust (YAS) and East Midland Ambulance Service NHS Trust (EMAS) and you have agreed that ambulance transfer will be an Interfacility Transfer Category 2. This means that the nearest available emergency ambulance will be dispatched immediately to the department to arrive within a mean time of 18 minutes. We are unsure how achievable that is amongst the competing ambulance priorities. The receiving point at the hospital is specified on page 6 of the SOP - the Emergency Department in Leeds Hospital, Radiology on C floor in Sheffield Hospital and the Interventional Radiology Suite in radiology in Hull Hospital. With long transfer times the panel have advised that many patients may need to be reimaged before treatment, and you will need to discuss if the proposed receiving point is

therefore the right location. We would also wish to see this ambulance service agreement reflected within the documentation.

Recommendation: *To confirm the ambulance protocol within the documentation*

We also understand that the ambulance services have requested that this service will operate the same rota as the cardiac surgeons will be using for the transfer of those with thoracic aortic dissections, which potentially will give YAS greater flexibility over repatriation.

There is a range in repatriation times currently between the 3 centres with Leeds repatriating the earliest (6 – 10 hours). The panel discussed if such a short turnaround time was in the best interests of the patient and there is a range of thought on this point. We note, however, that the repatriation time is determined by the patient's response to the thrombectomy and that all patients will be scanned after 24 hours. We were also pleased with your confirmation that there will be no repatriations overnight. You have been reassured by ambulance services that repatriation, when required, will be facilitated without delay.

The Senate noted within the patient information that it is not possible for relatives to travel in the ambulance. Some family members may not have their own transport to be able to travel independently to the MT centre and will be separated from their relative during a period when they are critically ill. YAS's own conveyance policy is more flexible than is stated in the patient information. It states that the decision as to whether relatives travel with the patient rests with the ambulance clinicians and must be based upon both the patient's needs and the practicalities of the patient's treatment. It also states that where the escort/carer has mobility and/or sensory impairment or mental capacity support needs; every effort should be made to transport them with the patient where this can be done safely and the patient's condition is not life threatening. Patients with dementia or learning disabilities should always be escorted by relatives, carers, or advocates where possible.

We understand that it is difficult to manage a patient's deterioration with relatives in the ambulance but the proportion of patients who deteriorate in the ambulance is small. The ambulance guidance is more flexible than is reflected in the patient information and we advise that the patient information reflects this.

Recommendation: *To reflect greater flexibility about the possibility of relatives travelling in the ambulance.*

Audit

Comprehensive audit is essential in monitoring the impact of these changes and you need to ensure that you have mechanisms in place to audit the whole pathway, from the first point of contact with a health care professional and not just the surgical results. The audit for this new rota needs to start at the point of presentation so that delays in definitive tests and issues with transit, for example, can all be monitored. Your audit should also measure the surgical outcomes in each of the 3 units.

Currently, the decision as to the level of joint governance for this arrangement has not been made and will be decided by the Integrated Stroke Delivery Networks (yet to be established).

We recommend that at the very least you will need an oversight group working jointly across Yorkshire and the Humber to review all referrals and use this time to reflect on practice and travel times and continue to develop and improve protocols.

Recommendation: *To establish a comprehensive auditing system for MT which captures the whole pathway from the point of query through to surgical outcomes with joint governance in place.*

Patient Experience and Information

Currently, you do not have any proposals in place to work with the patients and families of those who have undergone MT to find out what could have improved their experience of the process. You have stated that you would be happy to incorporate this into your work programme and see this fitting in to the future programmes of the Integrated Stroke Delivery Networks when these are established. We would certainly support this work with the patients and suggest that it should include the relative's perspective of being separated from the patient during their period of care in a MT centre.

Thank you for also sharing the Patient Information Leaflet. We are not sure if it has been commented on by the Stroke Association but advise that this may be helpful. Our lay members on the panel felt it could be written more positively. This is potentially a life changing intervention but the paragraph on the benefits of thrombectomy does not read very positively and this phrasing matters when you are making a decision in difficult circumstances.

One other comment is for commissioners to think about the potential difficult conversations with those families of patients who present in one of the referral centres on a weekend when they are not on rota. Learning that they must travel many miles to receive care in another centre, whereas they already understand that they are in a centre of excellence could be difficult and needs to be anticipated.

Recommendation: *To establish a process to gather information from patients, families and carers with a view to improving the patient experience*

Conclusion

We very much welcome your proposals to try to increase the number of hours in which you can provide this life changing intervention and we congratulate the Yorkshire and the Humber clinicians in trying to seek a solution during the years in which it will take for the workforce to grow.

The panel agrees that this interim solution is a very positive step forward and we wish to see the service expand whilst each centre develops its workforce to offer its own 7-day MT service. Whilst the panel is supportive of proposals that will safely deliver MT to more patients, we advise that there are significant challenges with the proposed model and questions on whether the projected weekend activity is achievable. This has led us to recommend that you consider further whether a single centre should be the focus for the weekend service and operators from the other sites travel to provide cover rather than trying

to rotate the site covering the region. We also recommend that you further explore the possibility of extended weekday working in parallel to weekend hours as this is a potentially easier mechanism to increase the number of patients treated. To streamline the pathway, we recommend that you simplify the communications between referral units and referring centres and ensure there is a solution to the issue of the image transfer. The need for comprehensive audit and joint governance also needs to be addressed within the model. Finally, our recommendations include building into the model a process to gather information from patients, families and carers with a view to improving the patient experience.

We hope our comments are helpful to you.

Yours sincerely

Chris Welsh
Senate Chair
NHS England – North (Yorkshire and the Humber)

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Review of proposals for mechanical thrombectomy in acute stroke in Yorkshire and the Humber on behalf of Yorkshire and the Humber Specialised Commissioning

Sponsoring Organisation: Specialised Commissioning

Terms of reference agreed by: Sarah Halstead, Specialised Commissioning Yorkshire and the Humber and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate

Date:

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1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Nicola Jay, Vice Chair of the Yorkshire and the Humber Clinical Senate

Citizen Representatives: Stephen Elsmere and Patricia McKinney

Senate Review Clinical Team Members:

Andrew Hodge	Consultant Paramedic Urgent Care	Yorkshire Ambulance Service
Dr Marcus Bradley	Consultant Neuroradiologist and clinical lead for Imaging	North Bristol NHS Trust
Dr Indira Natarajan	Clinical Director Neurosciences and Consultant Stroke Physician	University Hospital of North Midlands NHS Trust
Professor Helen Rodgers	Clinical Professor of Stroke Care	Newcastle University
Dr Paul Knight	Consultant Intensivist/ Anaesthetist	Calderdale and Huddersfield NHS Foundation Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

Is a regional Mechanical Thrombectomy (MT) service, delivered by each of the three MT centres (Hull, Leeds & Sheffield) on a one in three rotational basis, a suitable and acceptable interim solution to enable a MT service to be available during weekend days?

Objectives of the clinical review (from the information provided by the commissioning sponsor):

To provide independent clinical advice to Yorkshire and the Humber Specialised Commissioners to inform their future model of mechanical thrombectomy services. The advice will be used by specialised commissioning to develop appropriate plans, with key stakeholders, to enable a MT service to be extended to include weekend availability.

Scope of the review:

The Senate will answer the above questions based on the information provided in the documentation and the clinical panel will supplement their understanding of the model through discussion with commissioners.

3. TIMELINE AND KEY PROCESSES

Agree the Terms of Reference: by mid July 2019

Receive the evidence and distribute to review team: by 2nd October 2019

Meetings and Teleconferences:

Working Group Telecon 1 Wednesday 16th October and Friday 18th October

Working Group Telecon 2 Monday 4th November and Tuesday 5th November

Draft report submitted to commissioners: 15th November 2019

Commissioner Comments Received: within 10 working days of the draft report being received

Senate Council ratification; at the 22nd November 2019 Council meeting

Final report agreed: following Council ratification

Publication of the report on the website: within 8 weeks of ratification by the Senate Council

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- The document; 'MT Weekend Rota supporting document'

The review team will review the evidence within this documentation and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor and NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

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

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber 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.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. 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. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
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 team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

v. provide feedback to the Clinical Senate on the impact of their advice.

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 team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
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 team and
v. submit the final report to the sponsoring organisation

Clinical review team 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 team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. 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.

END