Appendix 2

Healthier Lancashire & South Cumbria

Lancashire and South Cumbria Care Professionals Board invited review of the Our Health Our Care model of care and proposed options for delivery

Review date: 19th July 2019

Report issued: 7th August 2019

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Executive Summary

On 19th July 2019 the Lancashire and South Cumbria Integrated Care System Care Professionals Board (CPB) conducted an invited informal review of the Our Health Our Care (OHOC) programme. In particular, the Care Professionals Board were provided with details of the Case for Change and Model of Care for the programme, along with details of the long list of options developed as a result. This included the initial recommendation from the programme's Clinical Oversight Group (COG) as to which of the options it believed were compatible with the Model of Care developed.

The CPB understood that the information that it received relating to the programme options was in a developmental and formative state. Further modelling and assurance information would be developed in the period before and following the visit of the North West Clinical Senate on 16th and 17th September. This further modelling and assurance information would support the programme with the development of its revised Pre-Consultation Business Case.

Summary Findings:

A. The review panel feels that the programme has developed and explained the options relating to acute sustainability programme of Our Health Our Care to a good standard. There is no relevant contra-indication to inviting the North West Clinical Senate to provide an independent clinical appraisal of the options developed, as scheduled in September.

B. The review panel considers that all possible options, relevant to the redesign and improvement of the acute system, working in conjunction with its partners, have been explored in the long list. The approach of using the clinical standards and co-dependency frameworks as an initial route to assessing viability or otherwise of the options is reasonable.

C. The level of clinical engagement with partners in the primary, community and acute systems towards the development and co-production of the options has been relevant and effective. The programme has also identified within its Model of Care how public engagement outcomes have influenced the development of the options.

D. The options identified within the longlist of options are in line with the 4 below tests as determined by the "*Planning, assuring and delivering service change for patients guidance"* (NHS England, 2018).

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support for proposals from clinical commissioners.

In terms of the 5th test, this is relevant to proposals that include the closure of beds. No option presented proposes any reduction in beds and therefore this test is not relevant in this case.

Clinicians tell a passionate and well thought out narrative that supports the proposals and provide further assurance as to them being both deliverable and the right thing to do. A focus on 5 key areas of learning and deploying best practice (including technology), partnership working, keeping momentum and stakeholder engagement, managing areas of potential risk and interdependency management will further enhance the proposals in readiness for decision making.

Overall, the CPB review team support the direction of travel as presented and the submission of more detailed proposals for formal review by the Clinical Senate.

Review Team

Jackie Hanson - Director of Nursing & Care Professionals NHSE/LSC, ICS Review Team Chair

Dr Mark O'Donnell - Medical Director Blackpool Teaching Hospitals NHS FT

Dr Gareth Wallis - Deputy Medical Director NHSE/I

Caroline Baines - Clinical Senate Manager (NW)

Kath Gulson - CEO Local Pharmaceutical Committee

Lynne Wyre - Director of Nursing University Hospitals of Morecambe Bay NHS FT

Dr Amanda Thornton - Digital Health Clinical Lead HLSC ICS

Dr Paul Dean - Consultant Anaesthesia & Critical Care Medicine Royal Blackburn Teaching Hospital

Dr David Ratcliffe - Urgent Care Clinical Lead for Greater Manchester Health and Social Care Partnership and Clinical Advisor (NWAS), GP with Special interests (ED)

Elaine Johnstone - Service Director CSU

Shirley Goodhew - Acting Consultant in Public Health Blackburn with Darwen Council

Dr Shirley Jackson - GP NHS East Lancashire CCG

Terms of Reference

Visit objectives

To conduct an informal review of the Our Health of Care Model of Care and proposed options, including providing opinion if all options resulting from the approved Model of Care have been considered in response to the Case for Change. The review team were specifically asked to consider the below 8 key lines of enquiry as is described within the West Midlands Clinical Senate Stage 2 Clinical Assurance Evidence Framework (2017).

1. Do these proposals deliver real benefits to patients?
    a. Do the proposals reflect the goals of the OHOC benefits framework?
    b. To what extent do local clinicians believe the proposals will deliver real benefits for service users and carers in the affected populations?

2. Is there evidence that the proposals will improve the quality, safety and sustainability of care?
    a. Is there clinical and other evidence which support the proposals?
    b. Where new technology is key to the delivery of proposals, is there evidence of its existence, functionality and effectiveness?
    c. Do the proposals demonstrate compliance with national guidance on workforce requirements including setting out their sustainability in terms of clinical workforce?

3. Do proposals reflect up to date clinical guidelines and national and international best practice?

4. Do the proposals reflect the goals of the NHS Outcomes Framework?
    a. Preventing people from dying prematurely
    b. Enhancing quality of life for people with long-term conditions
    c. Helping people to recover from episodes of ill health or following injury
    d. Ensuring that people have a positive experience of care
    e. Treating and caring for people in a safe environment and protecting them from avoidable harm

5. Do the proposals reflect the rights and pledges in the NHS constitution?
    a. rights about access to health services
    b. rights about quality of care and environment
    c. rights about patient choice
    d. rights about your own involvement in your healthcare

6. Is there a clinical risk analysis of the proposals and is there a plan to mitigate identified risks?
    a. The safety, effectiveness or experience of patient care
    b. The deliverability of the proposals - potential adverse impacts on related/co-dependent services (including destabilisation of services)
    c. Proposed physical solutions

d. The accuracy of activity, capacity, workforce projections and workforce risks
e. Formal modelling of any impact on Emergency Preparedness, Resilience and Response (EPRR) plans with mitigation where required.

7. Do the proposals demonstrate good alignment with the development of other health and care services?
    a. Do the options demonstrate how any changes to the configuration and delivery of services in the acute sector will be compatible and enabling of equivalent changes in primary care, partner organisations and community services (therefore demonstrating a whole system approach) and the wider ICS.

8. Do the proposals support better integration of services?

Background to the review

On 13 December 2018 the OHOC Joint Committee approved the programme's Case for Change. The Case for Change described the 5 key challenges that the OHOC programme should seek to act upon in its proposals for reform of the acute system, working with partners across the broader health economy, as part of a whole-system approach to transformation.

- **Workforce -** across our health and care system, including our local hospitals, we do not have the workforce that we need in critical areas.
- **Flow -** too many people wait too long for their care and too many people experience delays when they are in hospital.
- **Lack of Alternatives -** our patients do not have enough options for their care. This can result in increased use of urgent and emergency care services provided by our local hospitals.
- **Demographics -** the number of people in Central Lancashire is a growing and the population is ageing. Our local hospitals are not set up in the best way for the future to deal with these changing needs
- **Use of Resources -** as a health system, we are not making best use of the resources we have.

Following approval of the subsequent model of care on 13 March 2019 the programme was provided with the mandate to progress to the next stage of the programme, that is, to develop the options.

The formal stage 2 clinical senate review is scheduled for 16 and 17 September 2019 whereby a formal clinical review of the Pre-Consultation Business Case (PCBC) will take place. Discussions with the senate and programme team have advised that an informal review, comprising a subset of the whole senate remit, would support the OHOC Joint Committee in making its decision to submit the PCBC to the senate.

The CPB have been requested to undertake the informal review.

This report will advise if the options are responsive to the 5 above key challenges identified within the Case for Change, and if the options developed are open minded and take proper account of the agreed Model of Care, Clinical Standards and Co-Dependency Framework.

Documentation considered prior to the review visit

The review team received the below documents prior to their visit on 19th July 2019

1. Approved Case for Change
2. Approved Model of Care
3. OHOC Benefits framework draft version 0.5

4. Clinical viability of the options draft version 2
5. Financial evaluation of options 4 and 5 draft version 2
6. Approved review terms of reference

Summary Feedback from the Discussion Sessions

Do these proposals deliver real benefits to patients?

The review team found that the proposals reflected the benefits as expressed within the benefits framework. They aim to provide care closer to home while supporting consolidation of more specialist services, where this is required to achieve and maintain compliance with core national standards.

The clinicians interviewed all demonstrated a clear passion and support for change, involving working together with partners in primary, community and social care, for the common benefit of delivering transformed care outcomes for patients. They communicated clear frustrations relating to the time involved in the assurance process and the challenges of maintaining safe and effective clinical service delivery whilst proposals for the future are developed. Further, how the concepts of urgency and momentum was considered in the approach being taken to assurance and option refinement, so that benefits to patients could be accelerated and that adverse consequences for patients arising from delay, could be avoided. Clinicians described their frustrations with the lack of access to capital monies to improve care for patients, but described that the proposals must be developed now, and without further delay.

They acknowledged that to maximise significant benefits for the patients the transformation proposals developed within the Out of Hospital platform and existing Lancashire Teaching Hospital (LTH) improvement initiatives will also need to be realised. This would be part of a transformed vision about the role of the acute hospitals in delivering care to local communities. This would need to focus on preventing, as well as treating ill health, and delivering more care outside of the hospital system, in part facilitated by changing the relationship between hospital specialists and their primary and social care partners.

The clinicians involved in the review also cited some examples as to what they felt were positive components of working together across organisational boundaries.

<u>Examples of good work included:</u>

- Good evidence was presented with regards to the present Central Allocation Team for Community and Social Services (CATCH) and the ambulatory care service provided at Chorley Hospital, with evidence of uptake and good auditing of impact and outcomes. This great work should be developed further supporting greater integration of the services to realise an efficient single point of access / care streaming service.

- The home first scheme has successfully reduced admissions into community beds achieving a 2 hour response time form the CATCH team initial nursing / therapist review. Good relationships with LTH has developed. The service has a less than 5% return rate and 93% remain at home on day 5: this demonstrates the great benefits to patients already happening and should be celebrated.

- There are some early plans to rotate staff between NWAS and the hospital to support Pre-hospital/in-hospital integration. The proposals described some great opportunities for shared workforce roles and integration between the partners in the programme.

We agree that these do represent examples of positive working across organisational boundaries.

We feel that although many positive benefits can be realised through implementation of the out of hospital transformation schemes, and that these must form part of the way forward, they will not in themselves be sufficient to overcome the challenges within the hospital and as described within the Case for Change. Therefore, acute services need to be reconfigured and restructured in order for optimal changes in the full pathway to be achieved. This will need to occur in parallel to the out of hospital workstreams of the programme, with the requisite funding and workforce "following the patient."

The clinical teams clearly expressed to us that, of the options developed on the longlist, those described under number four are likely to deliver the greatest benefits for patients and there is an open-mindedness to consider variants including 4a, 4c, and 4d in particular. They would act as an enabler to quality and innovation.

We heard some evidence that movement on clinical workforce supply, training and development; working practices and structures; and innovations in practice would all be needed to make these a reality for patients. Those options developed under number five (5a, 5c and 5d) in particular would represent a "fall back" position, should these be not realisable, but the loss of access to ambulatory care could be perceived as a "step backwards."

The clinical teams we spoke to were not satisfied that options described under number three would present part of a viable, long-term sustainable to health care services in Central Lancashire, because the prevailing issues of delivery against core clinical standards, delivering economies of scale, and workforce accessibility could not be addressed. From their perspective, this would need to take precedence over alternative considerations such as current/forecast population size and planned demographic change, and some concerns held by the public relating to access times for healthcare. Overall, the clinical teams felt that beyond urgent and emergency care focusses, the broader proposals for outpatient, elective, and out of hospital care would significantly move more care closer to home, thereby improving population access.

Although not discussed in detail with the review team itself the clinical team have advised the programme team that there is no significant evidence that the population catchment for the combined populations of Chorley, Greater Preston and South Ribble would require local

access to either two or more Type 1 Accident and Emergency departments in the future, as described under option three. The clinical teams reported concerns that the existing service model was non-compliant with core standards for service availability and access. The present model for informally differentiating take for emergency care flows was not sustainable to reducing risk in the long-term.

During the course of the visit we did not acquire specific evidence relating to the effect of the service model developed from 2017 onwards. Therefore, we were unable to identify if this model had acted as a direct enabler to improvements in acute flow, patient experience, or the ability of the trust to attract, retain and develop clinical workforce teams in core areas. However, the public performance data still indicates challenges alongside reciprocal impacts linked to elective and non-elective pathway performance data. We formed an overall impression that delivering service models according to the current approach remained highly challenging and was not considered to be compatible with delivering improved flow, patient experience and operational performance.

Is there evidence that the proposals will improve the quality, safety and sustainability of care?

The relevant standards are clearly presented within the model of care, the delivery of which will be contingent on more detailed plans being developed around the shortlisted options to explain how these standards are going to be achieved. This will need to be developed before the final decision-making stage. Proposals would need to include areas such as workforce; recruitment, training and maintaining clinical staffing skills; digital enablers; enabling contractual reform; research and innovation; and partnership working approaches with primary and community sector partners.

In terms of the current proposals, good evidence was presented with regards to the present CATCH and the ambulatory care service provided at Chorley Hospital, with evidence of uptake and good auditing of impact and outcomes. This great work should be developed further supporting greater integration of the services to realise an efficient single point of access / care streaming service.

The programme has indicated that the existing commissioning arrangements for services are likely to continue within the framework of the current proposals which have been developed. These will change, over time, with the development of primary care networks, linked to broader national reform. At the decision-making stage, the programme will need to consider this in terms of the overarching governance structure. This will be important to ensure that there is an effective governance structure available to oversee improvements in safety, quality and sustainability arising from the proposals developed.

The clinical teams described concerns about their ability to deliver ambulatory care services on two sites with failed recruitment of acute physicians. The present GP referred ambulatory care service is only available at Chorley Hospital and feedback appears positive of this service across both CCG areas. The CPB suggests that consideration should be considered to a staged approach, whereby a full service is developed at the Chorley site for the wider

population in the more immediate term, and that this is replicated across both sites as medical recruitment allows. This will also depend on how far the agreement on the options to proceed with acts as an enabler to attract, develop and retain the necessary clinical workforce infrastructure.

The review team considered that although the use of technology, such as, remote monitoring and virtual approaches to delivering outpatient care has been considered this could be further explored within the proposals. In particular to improve communication structures between primary, community and secondary care, use of shared care records, and the use of new treatment technologies, such as robotics, should be identified for use where possible. There will be an opportunity to extend this thinking with the proposals developed, and also an opportunity to create partnership working opportunities with the research and academic community to ensure that patients continue to get expedited access to the benefits of best practice, where available.

The proposals described some opportunities for shared workforce roles and integration between the partners in the programme. For instance, there are some early plans to rotate staff between NWAS and the hospital to support Pre-hospital/in-hospital integration. There is an opportunity for the local primary care networks to express how shared working roles and interfaces between the secondary care and primary care sectors could act as an enabler to challenging the issues of GP recruitment and the development of portfolio-based careers.

Do proposals reflect up to date clinical guidelines and national and international best practice?

The review team found the clinical standard references to be up to date and relevant to the proposals presented. The programme team will need to ensure that as the proposals develop, that any extraneous and relevant changes to clinical standards framework, for instance arising from Royal College guidance are included in the proposals developed for implementation.

The proposals are formed on the basis of implementing care pathways. The clinical teams we spoke to recognised that in some instances, senior clinicians will continue to need be exercise their judgement for patients where their clinical presentation, history, and proposed management plan does not align with standard care pathways. This includes examples where actual diagnoses conflict with initial presentation and referral reason. We endorse the work that the clinical teams are doing to be flexible in their approach to the management of such patients.

The clinical teams provided examples of planned or actual deployment of clinical best practice within their services. Examples provided included enhanced recovery after surgery (ERAS+), the Post-Operative Care Unit at York, and the deployment of a respiratory assessment service. Where best practice is planned to be deployed, the clinical teams will benefit from visiting these areas both to acquire learning and also be able to express succinctly the clinical benefits arising from the implementation of such innovations in practice.

Within areas such as Critical Care and Surgery there are plans to develop new roles that are quite advanced. The clinical teams will need to continue their work in capturing and triangulating the potential use of technology in delivering a planned care service/site alongside new and innovative workforce roles.

Do the proposals reflect the goals of the NHS Outcomes Framework and the rights and pledges within the NHS constitution?

The review team were pleased to see that the proposals were clearly clinically led and had been developed arising from a good level of clinical engagement involving relevant partners. The voice of the patient had also been considered and there were good plans to continue engagement on this front, to ensure that the spirit and pledges in the NHS Constitution were met.

The proposals stem from a desire to deliver the best care possible within the available resources and the use of evidence to develop the proposals supports improved outcomes.

The proposals are aligned well to the goals of the NHS outcomes framework, although the review team further understood that the programme team had not used this approach specifically to present their ideas. This is acceptable, but as the proposals develop, the proposals for acute reform will need to complement the plans being developed across the health economy, including the integrated care partnership (ICP) and the clinical commissioning groups. This will help ensure how the proposals for acute reform will contribute to the overall health economy plan to respond to the NHS Long-Term Plan.

As the health economy moves towards a coordinated and integrated plan for delivering the outcomes and policy direction specified in the NHS Long-Term Plan, in practical terms, this will mean that the clinical teams will need to re-evaluate the traditional interfaces between out of hospital services and the acute trust. The clinical teams should consider how the governance framework for trusted triage and workforce and deeper service integration between out of hospital services and the acute trust can be further developed.

We were provided with examples of using clinical risk tools, referral thresholds, a single point of access approach to promote clinician to clinician dialogues, and the effective use of the principles of patient choice in decisions of how and where to refer services across the out of hospital and acute trust service boundaries. It will be important to continue this work and ensure that the health economy considers the governance framework as part of the implementation of its proposals.

Detailed bed modelling will need to demonstrate that the required capacity is available with each of the options so that patients can access the services with the higher standards that consolidation can bring. The proposal of protected capacity for surgical patients will indeed support timely access the planned care, however the team must be clear on the parameters where surgery becomes better placed on a site with a more specialist range of services. There is evidence that this is already happening, but clearer service specifications and transfer policies will be required as the options mature to the point of implementation.

In terms of the clinical service specification, the proposals would benefit from describing more clearly the management plan for paediatric patients and patients with acute mental health issues. The clinical team identified with us that the management plan for acutely unwell paediatric patients on the Chorley site was based on a stabilise and transfer model and that this risk should not be tolerated in the long-term with the proposals developed. Similarly, the existing infrastructure for supporting patients with acute mental health issues was better on the Preston site than it was on the Chorley site. On the latter point, the review team were pleased to see that Lancashire Care Foundation Trust (LCFT) were involved in the clinical development of the proposals. However, more consideration is needed on these points as the process of developing the options in more detail matures.

Is there a clinical risk analysis of the proposals and is there a plan to mitigate identified risks?

There is no clinical risk analysis at this stage, which will need to be developed as proposals mature alongside plans for Emergency Preparedness, Resilience and Response (EPRR).

We were impressed by a clear open culture of staff to learn from their service outcomes and being able to use raw data to drive service provision. For example, if a patient referral is refused, the team look into it in more detail to understand why.

We have identified the below seven key risks that work should begin to mitigate within the developing options.

1. Patients will not have clarity on which site to access urgent care or emergency care. This will need to be clearly understood and communicated to avoid presentation at the wrong service. We understand that this is also a risk associated with the current service model at Chorley, as the service does not meet the requirement of a Type 1 Accident and Emergency Department. This is particularly problematic with “walk in” patients who do not use one of the existing streams to manage inappropriate activity.

2. How do you make sure that everyone uses the Single Point of Access? A specific communication and mitigations plan will be needed, as this is a very difficult problem to solve.

3. Part of these interdependencies rely on the primary care networks, which are new and are different levels of maturity at this stage. There will be a requirement for the primary care networks to consistently prioritise the development of a clear implementation, governance and monitoring plan, based on the activities proposed to be transferred out of the acute system. This will need to be developed alongside their respective neighbourhood care strategies and the system-wide focus on prevention but should not be a reason to delay or defer making the necessary changes to the acute system. Workforce and financial support to accommodate this activity shift will need to be developed, but again in tandem with the need to respond to changes required now to the acute system

4. The options correctly present the alternative approaches to managing acute flows and coordinating the configuration of the urgent and emergency care system, and its

associated co-dependencies. The options describing an enhanced urgent treatment centre are potentially innovative.

Clearly, the overall proposals will develop and describe how the changes that arise from such a model match up with the reforms that the rest of the system will be able to achieve to maximise the chances of success. This will link to what role and types of activity the acute system will be required to manage in the future. It will also link to the improved streaming of patients to other partners, such as LCFT. It will also link to what support primary and community care providers can offer to the implementation of the concepts in the document – for instance in-reach medical workforce between primary and urgent care services.

5. The risk profile for the acute proposals and the delivery timelines should consider the possibility that co-dependent services are not matured to the point where they are able to take on the role fully of managing activities displaced from the acute system.

6. The clinical team advises that the programme team should consider the interface with partner organisations such as LCFT, model some of the impact on the urgent and emergency care system outside of the Central Lancashire ICP to understand this risk.

7. Staged approach to ambulatory care service development as described earlier in this report.

Do the proposals demonstrate good alignment with the development of other health and care services and support better integration of services?

During our visit we met with staff from both the acute sustainability and WHiNs platform as well as NWAS. This demonstrated they are working together with particularly good work progressing between the CATCH and Single Point of Access (SPOA) teams.

The review team considered that your proposals would benefit from describing more clearly the benefits realised from the existing whole pathway reforms which have been implemented across the out of hospital areas, and how this work can be accelerated linked to your longer-term strategic plans. This will improve the confidence around using this approach to redesign care on other pathways.

We feel that a focus on plans for Step Up and Step down processes should be a focus for the team as these are the key aspects that directly impact on admission avoidance and timely discharge from hospital care. Plans for staff rotation are really good and will support integration and understanding of services at the delivery level.

Conclusion

The review team feels that all options have been explored and support that the options identified within the shortlist are in line with the 4 below tests as determined by NHSE (2018) Planning, assuring and delivering service change for patients guidance, in particular tests 2 and 3 falling within the scope of this review.

1. Strong public and patient engagement

2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support for proposals from clinical commissioners.

Examples of good work was described such as the innovative plans to use their workforce differently as well as use technology to support the Critical Care service. There is some great work also already happening within the continually developing CATCH and SPOA Services and the use of raw data to drive service provision. More detail around existing transformation within the proposals would support any future conversation with the public and their confidence in them.

We have heard that the patients like ambulatory care if they know they are getting a good service and that they are willing to travel to it. Clinically the enhanced urgent treatment centre option is the preferred choice of the clinicians we spoke to yet there are concerns about how you can staff ambulatory services on 2 sites if you don't have the workforce to do this now.

The way that ambulatory care unit works is different at two sites currently. Preston is more of an acute assessment unit rather than ambulatory care unit and the team must think about the feasibility of providing a full service on 2 sites with their current workforce challenges. A staged approach may be more beneficial ensuring a full service is available to the population that really works as the priority step. This would need careful consideration as is a balance between local delivery, especially for elderly medical patients and its interaction with community urgent care versus deliverability of a service that is clearly the right thing to do.

Clinicians tell a passionate and well thought out narrative that if captured better supports the proposals and will provide further assurance as to them being both deliverable and the right thing to do. They communicate clear frustrations relating to the time involved in the assurance process and the challenges of maintaining safe and effective clinical service delivery whilst proposals for the future are developed.

We feel that proposals could be further enhanced by telling the story that reflects the rich discussions we had during this review with a focus on 5 key areas of learning and deploying best practice (including technology), partnership working, keeping momentum and stakeholder engagement, managing areas of potential risk and interdependency management will further enhance the proposals in readiness for decision making.

The Care Professionals Board review team support the direction of travel as presented and the submission of more details proposals for a formal review by the Clinical Senate.

Appendix 1 - Format of the Invited Review Visit

Time	Room	Item	Review Team /other
10.00 – 10.45	Lecture Room 3 EC1	Pre-meet CPB review team	All review team
10.00 – 10.45	Lecture Room 1 EC1	Pre-Meet LTH clinicians and wider OHOC team	
10.45 – 11.30	Lecture Room 3	Specialty discussion – Single Point of Access, Catch and the Front Door	Gareth Wallis – Group Chair Shirley Goodhew Sheila Jackson David Ratcliffe
10.45 – 11.30	Seminar Room 9	Specialty discussion – Medicine and the WHiNs platform	Mark O'Donnell – Group Chair Amanda Thornton Caroline Baines Kath Gulson
10.45 – 11.30	Seminar Room 2	Specialty discussion – Surgery and Critical Care	Lynn Wyre – Group Chair Paul Dean Jackie Hanson Elaine Johnstone
11.30 – 12.00	Lecture Room 3	Panel review of the morning and collate initial feedback	All review team
12.00 – 12.30	Seminar Room 9	Executive discussion	Review team group chairs Jackie Hanson Lynn Wyre Gareth Wallis Mark O'Donnell
12.30 – 13.00	Lecture Room 3 EC1	Informal Feedback session	All review team and attendees