East of England
Clinical Senate

## Great Yarmouth and Waveney CCG

# Report of the Clinical Senate Independent Review Panel

MARCH 2015

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**Document Version Control**

| Version | Author/s | Date | Status |
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| 1.0 Pre draft Not for circulation | S Edwards | 24.02.15 | For completion post panel |
| 2.0 | S Edwards | 01.03.15 | For completion post panel |
| 3.0 | S Edwards | 03.03.15 | Includes draft recommendations – to SG |
| 4.0 | S Gordon / S Edwards | 10.03.15 | S Gordon amendments – out to CCG and panel members for factual accuracy**. Not for further or onward circulation** |
| 5. | S Edwards | 17.03.15 | Minor changes on points of accuracy. To Senate council 25th March 2015 |
| 6 – Final | S Edwards | 26.03.15 | Minor typo amendments addition of biography.<br>Final version, sent to GYWCCG. |

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# 1. FOREWORD BY CLINICAL SENATE VICE CHAIRMAN

The NHS needs to continually modernise and transform in order to deliver high quality care now and for future generations. Clinical senates have a unique role in supporting the NHS in enhancing quality and delivering sustainability by providing independent clinical leadership and advice.

We need to ensure that the right balance is achieved between providing accessible services for patients and carers and making sure they are provided with high quality care by appropriately trained and experienced staff.

We hope that by bringing an expert clinical voice we can contribute in a positive way to the future development of the CCG's proposals to improve the care and sustainability of services for patients in Great Yarmouth and Waveney area.

I am grateful to Dr John Stammers, chairman of the Great Yarmouth and Waveney Clinical Commissioning Group, for inviting us to undertake the review as part of their assurance process. I commend Dr Stammers and his team for their clear and helpful presentations and documentary evidence which allowed the review to proceed effectively and to time.

I thank all the members of the panel for giving up their considered and insightful contribution to this important piece of work and to the East of England clinical senate support team for coordinating the review and this report.

I also offer my thanks to Dr Bernard Brett, East of England clinical senate chair, for asking me to undertake this review on behalf of the senate. Dr Brett excluded himself from the process as the review concerned, among other things, some services at the James Paget hospital where he works.

On behalf of the panel and the clinical senate, I wish all those involved in these service changes every success in achieving their ambitions to improve care for the people of Great Yarmouth and Waveney

Dr Shane Gordon,
Clinical Senate Vice Chairman

# 2. ADVICE REQUEST

2.1 The East of England clinical senate was approached by the Great Yarmouth and Waveney Clinical Commissioning Group (the CCG) to provide independent clinical advice on its whether elements of its case for change will safely deliver improved clinical benefits

2.2 The request was made in December 2014 and clarification of the scope of the request was developed during January and February 2015.

2.3 The review panel was asked to specifically look at the CCG's plans for community hubs and out of hospital teams across the Great Yarmouth and Waveney area. Alongside this the panel was asked to look at plans to redesign urgent care services for the area.

2.4 The east of England clinical senate was asked to review the documentation and evidence and consider:

a. The extent to which the proposals reflect up to date clinical guidelines and national and international best practice.

b. The extent to which the proposals are supported by evidence to show equity of service across Great Yarmouth and Waveney.

c. The extent to which the local evidence supports the roll out of Community Hubs and Out of Hospital teams in Great Yarmouth and Waveney.

2.5 The scope of the advice did not include the east of England clinical senate formulating or proposing any alternative options, even if its view was that it did not consider the proposals would deliver the benefits outlined in the business case.

2.6 Nor did the scope of review consider any financial implications, either negative or positive.

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

# 3. METHODOLOGY & GOVERNANCE

3.1 The scope of the review was discussed with the CCG to identify the most appropriate skills mix and expertise for the review panel and also the approach to be taken.

3.2 It was agreed that a desktop review of the evidence followed by a single panel day with the CCG was the most appropriate approach. It was agreed that site visits would not add any additional value or information to the evidence provided.

3.3 Terms of Reference for the review were drafted with the CCG and agreed and signed by Andrew Evans, Great Yarmouth and Waveney CCG Chief Executive Officer and Dr Shane Gordon, Vice Chairman of East of England clinical senate and council appointed Chairman of this review panel.

3.4 Senate Council support team identified clinical review panel members (see Appendix 2 for panel members) from the east of England senate council and assembly. Once the potential panel members had had been invited, accepted and had made any declarations of interest (there were none declared) and signed a confidentiality agreement, they were sent by email the documents and evidence provided by the CCG as its evidence base for the panel.

3.5 A pre-panel telephone conference with panel members was held two weeks before the panel day to identify the key lines of enquiry for the panel day in order that focus could be kept to the Terms of Reference of the review.

3.6 The key lines of enquiry were finalised and produced with the agenda (see Appendix 4) for the panel day, and circulated to the panel members and CCG one week prior to the panel day itself.

3.7 The clinical review panel took place between 10.00am and 4.00pm on 3rd March. The CCG was invited to make a short presentation to the panel to provide context for the evidence provided. The panel then followed up with questions following the identified key lines of enquiry.

3.8 A draft report was circulated on 11th March 2015 to panel members and the CCG for matters of accuracy.

3.9 This, final report, was submitted to a specially convened meeting of the East of England clinical senate council on 25th March 2015 for it to ensure that the clinical review panel meet and fulfilled the Terms of Reference of the review.

3.10 This report is then submitted to the sponsoring organisation, Great Yarmouth and Waveney Clinical Commissioning Group as part of its evidence for the NHS England service change assurance process.

3.11 Once that process has been completed, the East of England clinical senate will publish this report on its website as agreed in the review Terms of Reference.

# 4 Summary of key findings and recommendations

## Question one: integration of out-of-hospital services

### Key findings:

The panel considered that the information and data from the Lowestoft pilot presented, together with knowledge of success of other similar models, suggested that there would be a reduction in length of hospital stay and average length of stay.

The panel was of the opinion that in developing its model, the CCG had used a strong methodology of researching, looking at, visiting and learning from good practice as well as learning from its own pilot in Lowestoft. It was in a strong position to show success but needed a more structured approach to being able to evidence the desired outcomes with appropriate metrics. The CCG needed to ensure that it had a clear baseline, that it knew what good would look like and how it would measure progress against that.

### Recommendation 1

The CCG should identify ways in which it will measure the experience and satisfaction of its patients and professionals within the system to assist with the evaluation of its changes.

### Recommendation 2

The CCG should clarify how it will demonstrate the impact of the proposed changes in terms of patient benefits and the quality of the new services.

## Recommendation 3

The CCG, in its further deliberations with local stakeholders, should provide further detail on existing and future workforce, training and detail around the localities including staffing arrangements and staff confidence to deliver the model.

## Recommendation 4

The CCG should review its Equality Impact Assessment documentation and process. It may be helpful to seek further expert external assurance on this part of the planning.

## Recommendation 5

The CCG should make more explicit the extensive work it had undertaken, particularly providing detail about engagement with different population groups including minority and hard-to-reach groups.

# Question two: urgent care.

# Key findings:

From the evidence provided, the panel was clear that the proposal was a model in development and that more analysis and modelling is required to assure the CCG that it will deliver equitable access to urgent care services. **RECOMMENDATION:** The CCG should review, test and if necessary refine or modify the proposal following the planned public consultation.

The data provided by the CCG regarding the pilot urgent care centre at James Paget Hospital site did not suggest that the model was yet able to deliver the desired outcomes, particularly in relation to the diversion of attendances from A&E to primary care services.

The panel was satisfied that there had been patient involvement in the planning so far and recognised that extensive further involvement would take place through the consultation programme.

## Recommendation 6

The recommendation in relation to the Equality Impact Assessments provided for out-of-hospital care should be followed equally for urgent care.

## Recommendation 7

The CCG had made very recent changes to the model of care delivery in this pilot and should review the outcomes of that to inform the specification for additional urgent care centres.

## Recommendation 8

The panel recommended that once the CCG made changes or refinements to the model as a result of further evidence, data and information gathered through the public consultation process, the CCG should consider requesting that the clinical senate review the proposal in the light of changes and so be provided with further assurance that from a clinical perspective the model would deliver improved outcomes

## Recommendation 9 – Out of Hospital service & urgent care public consultation

The panel supports Great Yarmouth and Waveney CCG in holding a public consultation regarding services in its CCG area. The panel **recommends** that the consultation is directed towards implementation of the Out of Hospital Team Model, but that it should be used to refine and develop the system plans for urgent care.

# 5. Background

## Extract from the CCG's clinical evidence for change document and supporting evidence

5.1 The CCG is facing a challenging financial picture and for this reason it is important we look at everything we commission and consider how we can do this more effectively in future years. In September 2014 NHS Great Yarmouth and Waveney Clinical Commissioning Group Governing Body approved the move to pre consultation for 'The Shape of the System' consultation. The consultation will look at how health and social care services can be better provided and at a consistently high level right across Great Yarmouth and Waveney. The scope of the consultation will cover the shift of services provided in hospitals across our communities closer to people's homes, including community hospitals, primary care in Gorleston and urgent care services across Great Yarmouth and Waveney.

5.2 NHS Great Yarmouth and Waveney's 'Shape of the System' consultation was developed to deliver the CCG's vision set out in its Five Year Strategy, Urgent Care Strategy and the Out of Hospital strategy.

These strategies are in line with NHS England's Five Year Forward View[1] to*: 'take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care.'*

5.3 The CCG's Urgent Care Strategy is in line with the ambition: *'Across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.'*

[1] NHS England, October 2014

5.4 The case for integration of health and social services is clear. The pre consultation process will set the context for the public consultation. This approach will ensure that budgets are spent in the most effective way, duplication is reduced everyone receives the right treatment in the right place at the right time.

5.5 The implementation of the integrated model has already begun in Lowestoft following a successful public consultation there in 2013. The new out of hospital team in Lowestoft delivers targeted care in people's own homes and has already reduced hospital admissions by around 10% in just eight months. The vision of this consultation is to roll out similar initiatives across Great Yarmouth and Waveney. It will concentrate on a total plan covering every aspect of health care and social care services, right across the area.

# 6. REVIEW AND RECOMMENDATIONS

## Question one: integration of out-of-hospital services

6.1 Does the clinical senate clinical review panel consider that the proposed model for community hubs and out of hospital teams (with a focus on the over 75s) will safely deliver the clinical benefits outlined in the business case?

- Reduced numbers of emergency admissions in the over 75s compared to the anticipated levels (noting the demographic increase against baseline).

- Reduction in occupied bed days in the over 75s in Great Yarmouth and Waveney acute and community beds.

6.2 The panel heard that CCG had learned from the Lowestoft pilot and that roll out of the model would see further developments, including joint appointments between health and social care. The Lowestoft pilot had demonstrated a net reduction of admissions (from June to December 2014) of around six percent and for the over 75 years population group this was in the region of 11 per cent. This equated to around 1030 actual bed days.

6.3 There had been a corresponding reduction of actual admissions for the over 75 years population of around 30 percent for three major categories of hospital admission: a) falls, b) non-specific (not further categorised) and c) respiratory infections.

6.4 Workforce is a key part to the success of the model, in particular having the right skills in the right place. The panel was provided with more detail on planned workforce development, training proposals and the competencies for staff.

6.5 The CCG recognised that integration of information systems would be challenging. This model was a means of trying to move to a truly integrated system with a single commissioning plan moving away from organisational boundaries and providers and staff working together to deliver care. However, the CCG has a good foundation for sharing clinical information with 100% uptake of the Summary Care Record and the Eclipse information system in place in all practices.

6.6 The model represented services to the value of £5million or around 1.3 percent of the CCG's budget.

6.**7** **KEY FINDING: The panel considered that the information and data from the Lowestoft pilot presented, together with knowledge of success of other similar models, suggested that there would be a reduction in length of hospital stay and average length of stay.**

6.8 The panel noted the modelling work that had been undertaken and considered that the CCG was in a good position to demonstrate success. The CCG will need to be clear about its criteria for success and how they will be measured. The CCG is seeking improved outcomes for its patients and the health / care system. **RECOMMENDATION: The CCG should identify ways in which it will measure the experience and satisfaction of its patients and professionals within the system to assist with the evaluation of its changes.**

6.9 The panel was of the opinion that the CCG gave a good account of its plan for integration **out out-of-hospital care. RECOMMENDATION: The CCG should clarify how it will demonstrate the impact of the proposed changes in terms of patient benefits and the quality of the new services.**

6.10 The panel agreed that the responses provided by the CCG around workforce gave a better understanding and provided some assurance. **RECOMMENDATION: The CCG, in its further deliberations with local stakeholders, should provide further detail on existing and future workforce, training and detail around the localities including staffing arrangements and staff confidence to deliver the model.**

6.11 The panel considered that the CCGs Equality Impact Assessment document presented by the CCG relating to the out-of-hospital care, was not sufficiently detailed and therefore did not give assurance that the impact of the proposed changes on protected groups and others suffering health inequalities had been adequately considered**. RECOMMENDATION: The CCG should review its Equality Impact Assessment documentation and process. It may be helpful to seek further expert external assurance on this part of the planning.**

6.12 From the evidence provided by the CCG, it became clear to the panel that there had been patient and public involvement **RECOMMENDATION: the CCG should make more explicit the extensive work it had undertaken, particularly providing detail about engagement with different population groups including minority and hard-to-reach groups.**

## General comments

6.13 **KEY FINDING:** The panel was of the opinion that in developing its model, the CCG had used a strong methodology of researching, looking at, visiting and learning from good practice as well as learning from its own pilot in Lowestoft. It was in a strong position to show success but needed a more structured approach to being able to evidence the desired outcomes with appropriate metrics. The CCG needed to ensure that it had a clear baseline, that it knew what good would look like and how it would measure progress against that.

## Question two: urgent care.

Does the clinical senate clinical review panel consider that the proposed model for urgent care (to include Greyfriars, urgent care centres and primary care in Gorleston) will safely deliver the clinical benefits outlined in the business case?

- Do the plans for urgent care support the principle of equity of access for patients across Great Yarmouth and Waveney?
- Do the proposals reflect up to date clinical guidelines and national and international best practice?

6.14 The CCG confirmed that from its experience and data, it was clear that its seasonal population would generally continue to use the existing A&E facility and this had been taken into account in its planning.

6.15 The CCG provided information on public transport access for the proposed new centres.

6.16 **KEY FINDING: From the evidence provided, the panel was clear that the proposal was a model in development and that more analysis and modelling is required to assure the CCG that it will eviler equitable access to urgent care services. RECOMMENDATION: The CCG should review, test and if necessary refine or modify the proposal following the planned public consultation.**

6.17 The panel considered the Equality Impact Assessment document in relation to the question about urgent care to be inadequately detailed. The panel and CCG agreed that the comment on the key line of enquiry would stand i.e. that those provided were inadequate, particularly in relation to the “views of the relevant consultative groups” which were insufficiently detailed and also in relation to the analysis of potential impact on deprived or protected groups**. RECOMMENDATION: the recommendation in relation to the Equality Impact Assessment provided for out-of-hospital care should be followed equally for urgent care.**

6.18 **KEY FINDING: The data provided by the CCG regarding the pilot urgent care centre at James Paget Hospital site did not suggest that the model was yet able to deliver the desired outcomes, particularly in relation to the diversion of attendances from A&E to primary care services. RECOMMENDATION: The CCG had made very recent changes to the model of care delivery in this pilot and should review the outcomes of that to inform the specification for additional urgent care centres.**

6.19 The panel considered that the CCG needed to gather more data to develop the model that works for patients; that it needed to consider the whole system and to demonstrate how the proposal would take people away from A&E front door and into the new centres. The panel recommended that the CCG might also consider providing its evidence that the new centres would not end up being more of the same, existing centres with a new name and / or location but would be providing services that would improve outcomes and that patient's would value.

6.20 **RECOMMENDATION: The panel recommended that once the CCG made changes or refinements to the model as a result of further evidence, data and information gathered through the public consultation process, the CCG should consider requesting that the clinical senate review the proposal in the light of changes and so be provided with further assurance that from a clinical perspective the model would deliver improved outcomes.** This would provide the CCG an opportunity to further develop its Equality Impact Assessments demonstrating an analysis of any impact in relation to deprived or protected groups and that the proposal would not increase inequalities in any group.

6.22 **KEY FINDING**: The panel was satisfied that there had been patient involvement in the planning so far and recognised that extensive further involvement would take place through the consultation programme.

## General comments

The panel was of the opinion that the CCG was in the early stages of development of this model and some refinement, particularly in consistency of terminology and language was necessary before used in public consultation. The panel would be pleased to support the CCG in providing clinical assurance of its proposals should it wish it to review the proposals post public consultation.

The panel supports Great Yarmouth and Waveney CCG in holding a public consultation regarding services in its CCG area. The panel **recommends** that the consultation is directed towards implementation of the Out of Hospital Team Model, but that it should be used to refine and develop the system plans for urgent care.

A number of observations and more minor recommendations were made by the panel which should be addressed prior to the public consultation:

a. The terminology and language was applied inconsistently in the documents provided, particularly in relation to place names / names of facilitates, leading to some confusion. It recommended that there was a stated definition of the function of each type of centre and the difference between them made clear (i.e. centres and hubs)

b. The panel felt that the terms used to describe the facilities for different services were sufficiently similar as to risk causing confusion. For example, it was unclear to the panel what were the key differences between sites that were out-of-hospital 'hubs' and the urgent care centres and whether some of these were co-located. It was also not clear whether all the out-of-hospital hubs would offer patient accessible services at that site. The panel recommend that the CCG improve the clarity of this for the public consultation.

## Appendix 1: Terms of Reference for the review

**East of England Clinical Senate**
**Independent clinical review panel for**

**Great Yarmouth and Waveney CCG**

**3rd March 2015**

# Terms of Reference



## CLINICAL REVIEW: TERMS OF REFERENCE

**Title: The Shape of the System: Developing Modern and Sustainable Health Services in Great Yarmouth and Waveney**

**Sponsoring Organisation: Gt Yarmouth and Waveney Clinical Commissioning Group**

**Clinical senate: East of England**

**NHS England sub regional: East**

**Terms of reference agreed by: Dr Shane Gordon**

**on behalf of east of England clinical senate and**

**Andrew Evans, Chief Operating Officer**

**on behalf of sponsoring organisation Gt Yarmouth & Waveney CCG**

**Date: 16th February 2015**

## Clinical review team members

| | |
|---|---|
| Dr Shane Gordon | Chairman of Review Panel<br>Vice Chairman east of England clinical senate council<br>GP/ Chief Clinical Officer North East Essex CCG |
| Michael Dimov | General Manager Adult Services<br>London North West Healthcare NHS Trust<br>(formerly) Associate Director Clinical Services, Community Nursing South Bedfordshire, SEPT Community Services |
| Dr Robert Florance | Consultant in Emergency Medicine,<br>Queen Elizabeth Hospital Kings Lynn |
| Gail Foord | General manager Ambulatory care / Lead AHP<br>Hertfordshire Community NHS Trust |
| Dr Duncan Forsyth | Consultant Geriatrician, Cambridge University Hospitals Foundation Trust, Addenbrookes Hospital |
| Gavin Hickman | State Registered Paramedic,<br>East of England Ambulance Service NHS Trust |
| Dr Robert Lindfield | Public Health Consultant, Public Health England |
| Jayne Peden | Head of Quality & Safety<br>PROVIDE CIC |
| Ann Russell | Patient and Citizen representative,<br>Senate Council and Citizen's senate council member |
| Jane Scullion | Respiratory Nurse Consultant<br>University Hospital of Leicester NHS Trust |
| Dr Peter Skew | Essex GP<br>Clinical Director, Anglia Community Enterprise CIC |
| Dr Dee Traue | Medical Director St Isobel Hospice<br>Palliative Care Consultant, East & North Herts NHS Trust<br>Senate council member |

## Aims and objectives of the clinical review

The clinical senate is asked advise whether **the proposed model will safely deliver the following clinical benefits outlined in the business case?**

1. Community Hubs and Out of Hospital teams (with a focus on the over 75s)
    - Reduced numbers of emergency admissions in the over 75s compared to the anticipated levels (noting the demographic increase against baseline).
    - Reduction in occupied bed days in the over 75s in Great Yarmouth and Waveney acute and community beds.
2. Urgent care (to include Greyfriars, urgent care centres and primary care in Gorleston)

    - Do our plans for urgent care support the principle of equity of access for patients across Great Yarmouth and Waveney?
    - Do the proposals reflect up to date clinical guidelines and national and international best practice?

## Scope of the review

The clinical senate review panel is asked to review the available evidence (Appendix One) and make recommendations

**Aims and objectives of the clinical review**
The review will specifically look at the CCG plans for Community Hubs and Out of Hospital teams across the NHS Great Yarmouth and Waveney area. Alongside this the review will look at plans to redesign urgent care services for the area.

**Scope of the review**
The East of England Clinical Senate is asked to review the documentation and evidence and consider:

d. The extent to which the proposals reflect up to date clinical guidelines and national and international best practice.

e. The extent to which the proposals are supported by evidence to show equity of service across Great Yarmouth and Waveney.

f. The extent to which the local evidence supports the roll out of Community Hubs and Out of Hospital teams in Great Yarmouth and Waveney.

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

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

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

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

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

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

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

## Timeline

The review panel will be held on 3rd March 2015

## Reporting arrangements

The clinical review team will report to the clinical senate council which will ensure the report meets the agreed terms of reference, agree the report and be accountable for the advice contained in the final report.

## Methodology

The review will be undertaken by a combination of desk top review of documentation and a review panel meeting to enable presentations and discussions to take place.

## Report

A draft report will be made to the sponsoring organisation within six working days of the clinical review panel for fact checking prior to publication.

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

Final report will be submitted to clinical senate council to ensure it has met the agreed terms of reference and to agree the report.

The final report will be submitted to the sponsoring organisation by 27th March 2015.

## Communication and media handling

Communications will be managed by the sponsoring organisation. Clinical senate will publish the report once the service change proposal has completed the full NHS England process. This will be agreed with the sponsoring organisation

## Resources

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

The clinical review team may request any additional existing documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

## Accountability and Governance

The clinical review team is part of the east of England clinical senate accountability and governance structure.

The east of England clinical senate is a non statutory advisory body and will submit the report to the sponsoring organisation.

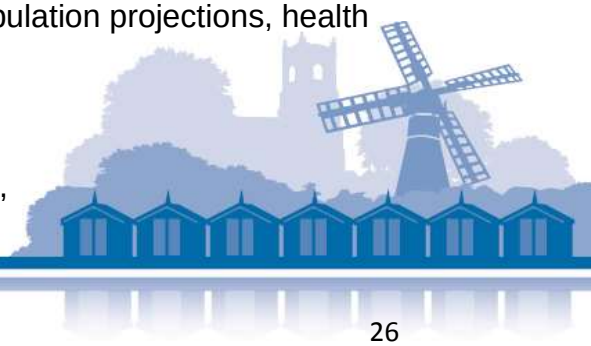
The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing its proposals.

## Functions, responsibilities and roles

The **sponsoring organisation** will

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

- relevant public health data including population projections, health inequalities, specific health needs
- activity date (current and planned)
- internal and external reviews and audits,



- relevant impact assessments (e.g. equality, time assessments),
- relevant workforce information (current and planned)
- evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions).

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.

### 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. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review ( as defined in methodology).
iii. contribute fully to the process and review report
iv. ensure that the report accurately represents the consensus of opinion of the clinical review team
v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest that may materialise during the review.

## Summary of process

**Stage 1**

- Sponsoring organisation (SO) requests clinical review of Senate as part of NHS England assurance process 1
- Senate office 2 review nature and scope of proposals to ensure appropriate for review

**Stage 2**

- Senate office and SO agree early stage Terms of Reference, in particular agreeing the timeline & methodology
- Senate council appoints Lead member / chair of clinical review team

**Stage 3**

- Senate office, Senate Chair and clinical review team chair identify and invite clinical review team members
- Clinical review team members declare any interests, these are considered by Senate and CRT chairs
- Clinical review team members confirmed, confidentiality agreements signed

**Stage 4**

- Terms of reference agreed and signed
- SO provides clinical review team with case for change, options appraisal and supporting information and evidence
- Clinical review commences, in accordance with the agreed terms of reference & methodology

**Stage 5**

- On completion of the clinical review, report drafted by CRT and provided to the SO to check for factual accuracy
- Any factual inaccuracies amended, draft report submitted to and considered by Clinical senate council
- Senate council ensures clinical review and report fulfils the agreed terms of reference

**Stage 6**

- Any final amendments made > Clinical senate Council endorses report & formally submits to sponsoring organisation
- Sponsoring organisation submits report to NHS England assurance checkpoint
- Publication of report on agreed date

# Appendix 2: Membership of the review panel

## Chairman of review panel

**Dr Shane Gordon**

**Chief Operating Officer, Colchester Hospital University NHS Foundation Trust**
**GP / Chief Clinical Officer North East Essex CCG**
**Vice Chairman East of England clinical senate council**

Shane took up his new position as Chief Operating Office for Colchester Hospital shortly before the panel review. Prior to that, Shane was the Accountable Officer for North East Essex CCG and a GP in Colchester. Formerly an Associate Medical Director for NHS East of England and Honorary Senior Fellow at Anglia Ruskin University, he has more than 10 years' experience leading NHS service development and redesign. He is a champion of public involvement, clinical leadership and quality improvement.

## Panel members

**Michael Dimov**
**General Manager Adult Services, London North West Healthcare NHS Trust**
(formerly) Associate Director Clinical Services, Community Nursing South Bedfordshire, SEPT Community Services
Senate assembly member

**Dr Robert Florance**
**Consultant in Emergency Medicine, Queen Elizabeth Hospital Kings Lynn**
**Senate assembly member**

**Gail Foord**
**Deputy Director of Operations/ Genera; manager Ambulatory care / Lead AHP**
**Hertfordshire Community NHS Trust**
**Senate assembly member**
Gail is a registered Physiotherapist and has extensive operational and strategic experience. She has also worked in consultancy as part of HM Treasury and the Local Government Association. This included Gateway Reviews of strategic projects. She has a Master's degree in Action Research and well developed commercial business skills including financial and performance management, contract management, tendering and business development.
Gail has a passionate commitment to improving the quality of services for patients and carers.

**Dr Duncan Forsyth**
**Consultant Geriatrician, Cambridge University Hospitals Foundation Trust, Addenbrookes Hospital**
Duncan has 24yrs experience as a consultant geriatrician and was clinical director for Medicine for the Elderly at Addenbrooke's Hospital 1996-2002. He chairs the Steering Group for the National Audit of Intermediate Care. He runs a Parkinson's service in Cambridge, and a delirium ward at Addenbrooke's Hospital where he is also the Trust delirium lead. He has been secondary care adviser to West Essex CCG since 2012.

**Gavin Hickman**
**State Registered Paramedic, East of England Ambulance Service NHS Trust**
**Senate assembly member**
Gavin is a State Registered Paramedic and has worked in varying roles in his 15 years' service. Gavin specialises in hazardous environment working and Resilience which covers the entirety of the East of England. He is passionate about the NHS developing a strategic platform for improving clinical care and out of hours services in the community.

**Dr Robert Lindfield**
**Public Health Consultant, Public Health England**
**Senate Council member**
Dr Robert Lindfield is a Consultant in Public Health at Public Health England covering East Anglia and Essex. He has a focus on healthcare, particularly primary care and quality, across the region and represents Public Health England on the Strategic Clinical Networks for cardiovascular disease and cancer, the Clinical Senate and the Quality Surveillance Groups. Robert trained originally in ophthalmology and maintains an interest in ophthalmic public health as a Clinical Lecturer at the London School of Hygiene and Tropical Medicine where he has an interest in quality of cataract surgery in developing countries.

**Jayne Peden**
**Head of Quality & Safety, PROVIDE CIC**
**Senate assembly member**

**Ann Russell**
**Patient and Citizen representative, Senate Council and Citizen's senate council member**
Ann has widely represented the patient experience and voice including as a member of the Cambridgeshire and Peterborough Quality and Patient Safety group and Enhanced Recovery Steering Group and has been a CCG Lay Chair and Accountable Officer.

Ann has represented patients at national level and held a number of roles on the National Cancer Research Network. She has also been involved in the design and management of five cancer trials and in the development of a website to enable patients to search for clinical trials throughout UK and Europe.

**Jane Scullion**
**Respiratory Nurse Consultant, University Hospital of Leicester NHS Trust**
**East Midlands Senate assembly member**

**Dr Peter Skew**
**Essex GP & Clinical Director, Anglia Community Enterprise CIC**
**Senate assembly member**
Dr Peter G Skew is currently the clinical lead GP at Green Elms Health Centre, which serves the Jaywick ward in Clacton-on-Sea, the most deprived area in England. Previously he has been, in a 39 year career in medicine, a Hospital and community Musculoskeletal physician and a GP in private practice for 18 years.

**Dr Dee Traue**
**Medical Director St Isobel Hospice, War, Hertfordshire**
**Palliative Care Consultant, East & North Herts NHS Trust**
**Senate council member**
Dee is a Consultant in Palliative Medicine at East & North Herts NHS Trust and Medical Director of Isabel Hospice in Welwyn Garden City.
Dee is also involved nationally in the palliative and end of life care arena, working for the charity *Help the Hospices* and as part of the Association for Palliative Medicine executive committee and a member of the RCP Joint Specialty Committee for Palliative Medicine.

## In attendance at the panel:

**Great Yarmouth and Waveney Clinical Commissioning Group:**

Andy Evans, Chief Executive

Dr John Stammers, CCG Chair

Carl Dodd, System Development Manager

Rebecca Driver, Director of Engagement

Cath Gorman, Director of Quality and Safety

Jane Hackett, Programme Manager

Fran O'Driscoll, Strategic Projects Manager

Tracey Parkes, Head of System Integration Development

Dr Jamie Wyllie, Director of Clinical Transformation

**Clinical Senate Support Team:**

Sue Edwards, East of England Clinical Senate Manager, NHS England

Jocelyn Whittle, Senior Administrative Support East of England clinical senate

Tracy Bentley, NHS England area team

Tim Roberts Ubiquis transcribing service

# Appendix 3: Declarations of Interest

| Name | Personal pecuniary interest | Personal family interest | Non-personal pecuniary interest | Personal non-pecuniary interest |
|---|---|---|---|---|
| Shane Gordon | None | None | None | None |
| Michael Dimov | None | None | None | None |
| Robert Florance | None | None | None | None |
| Gail Foord | None | None | None | None |
| Duncan Forsyth | None | None | None | None |
| Gavin Hickman | None | None | None | None |
| Robert Lindfield | None | None | None | *Declared – see below* |
| Jayne Peden | None | None | None | None |
| Ann Russell | None | None | None | None |
| Jane Scullion | None | None | None | None |
| Peter Skew | None | None | None | None |
| Dee Traue | None | None | None | None |

*Robert Lindfield: Declared that wife was Director of Public Health in Suffolk County Council. Panel Chairman and Senate Manager confirmed that this would have no influence or impact on the matter and Robert Lindfield could remain on the panel.*

# Appendix 4: Key lines of enquiry

<table>
<tr><th colspan="2">Key Lines of Enquiry</th></tr>
<tr><td colspan="2">Question 1: Does the clinical senate clinical review panel consider that the proposed model for community hubs and out of hospital teams (with a focus on the over 75s) will safely deliver the following clinical benefits outlined in the business case?<br><br>• Reduced numbers of emergency admissions in the over 75s compared to the anticipated levels (noting the demographic increase against baseline).<br>• Reduction in occupied bed days in the over 75s in Great Yarmouth and Waveney acute and community beds.</td></tr>
<tr><td>Timing allocated</td><td>Key line of Enquiry</td></tr>
<tr><td>30 mins</td><td>i) Modelling of system capacity / bed usage. The panel wish to see evidence of this and considerations of:<br><br>• Trends over preceding years and the expected impacts of the new model on different HRGs or OPCS codes. This would give some assurance that the new model will address avoidable admissions and deliver the desired benefit. The panel note that Ambulance calls and A&E attendances are rising and existing WIC usage is falling (2013/14 vs 2012/13 data provided).<br>• Anticipated volumes moving from hospitals (acute and community) into new settings. The concern is whether there is sufficient capacity in the new model.</td></tr>
<tr><td>30mins</td><td>ii) Workforce planning & modelling: more clarity on staffing, workforce development, pump priming for training. The concerns are:<br><br>• Spreading the workforce over more sites may reduce availability<br>• The transition to the new service will require some double running with the risk that hospital staff move to the new model early leaving that service understaffed. Considerations of Francis / NICE safer staffing requirements.<br>• What are the acuity levels of patients they intend to manage in the community? Are there corresponding skills in the staff? Has appropriate equipment provision been factored in? The panel note that Minors activity in A&E is falling while Majors has risen by 28%</td></tr>
</table>

| | |
|---|---|
| | year-on-year (2013/14 vs 2012/13 data provided) |
| **20mins** | **iii) Degree of integration intended**. This includes:<br>• Infrastructure to support shared care i.e. IT systems, shared data/ records<br>• Clarity on the joint teams in the community hubs in terms of co-location, shared management etc.<br>• What will prevent "boundary disputes" over which agency should fund care for patients, for example the Continuing Care vs Continuing Health Care issues? |
| **20mins** | iv) **Experience from the Lowestoft pilot – what risk and issues have been identified. How will these be managed and mitigated in the new model?** |
| | |
| **Question 2:** Does the clinical senate clinical review panel consider that the proposed model for urgent care (to include Greyfriars, urgent care centres and primary care in Gorleston) will safely deliver the clinical benefits outlined in the business case?<br>• Do the plans for urgent care support the principle of equity of access for patients across Great Yarmouth and Waveney?<br>• Do the proposals reflect up to date clinical guidelines and national and international best practice? | |
| **10 mins** | v) **How will the CCG ensure "patient capture" in the new model?**<br>• There is a transient / seasonal population. They will not be as aware of the new model and may bypass this to Ambulance or A&E. Is this included in modelling? |

| | |
|---|---|
| **20mins** | **vi) Equity of access. Evidence was provided only of driving times analysis. The panel wish to know:**<br>• **What analysis has there been of public transport time / availability / access and of community transport availability / access/ funding**<br>• **What analysis has there been of the differential impact of these changes on the access for patients in deprived communities and within protected groups** |
| **10 mins** | vii) **The Equality Impact Assessments.** Those provided were regarded by the panel as inadequate, particularly in relation to the "views of the relevant consultative groups" which were insufficiently detailed and also in relation to the analysis of potential impact on deprived or protected groups. This is a vulnerability in planning which has been used to successfully challenge service changes previously. The panel need further assurance that these considerations have been given adequate attention. |
| **10 mins** | viii) **Patient involvement in planning. The panel need to understand how patients have been involved in**:<br>• The design of the new service model<br>• The selection of outcome / success measures |
| **10mins** | ix) **Informed patient choice**. The panel are keen to understand how patients will be offered informed choices about their options for access to services? |

# Appendix 5: Summary of documents provided by the CCG as evidence to the panel

a. Clinical Evidence for clinical senate, March 2015
b. Copy of A&E Minors & Majors (December to April 2012/13 and 2013/14)
c. Copy of System Resilience Group Activity Tracker 2012/13 and 2013/14
d. Clinical Service Review Wards 12 & 18 James Paget Hospital, August 2014
e. Clinical Service Review 2014 ECCH Community Hospitals
f. Clinical Service Review Lowestoft Out of hospital team, February 2015
g. Equality Impact Assessment – out of hospital care, December 2014
h. Equality Impact Assessment – Urgent Care Strategy, December 2014
i. Urgent Care Strategy, November 2014
j. Lowestoft Out of Hospital Team Activity April to November 2014
k. Out of Hospital Strategy, January 2013
l. Phase 1 Urgent Care Centre Update report, February 2015
m. Shape of the system case for change V14 clinical senate, February 2015
n. Shape of the system consultation – a summary, January 2015
o. Urgent care update, October 2014

**Supporting documents**

p. Supporting Community services: Ambition, Action, Achievement – transforming Rehabilitation Services, (Dept of Health, 2009)
q. Gt Yarmouth & Waveney CCG five year strategic plan (June 2014)
r. Gt Yarmouth and Waveney CCG Commissioning Intentions 2015