Herts Valley CCG for West Hertfordshire Health and Care System

Report of the Clinical Senate Independent Review Panel

July 2015

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1. FOREWORD BY CLINICAL SENATE 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.

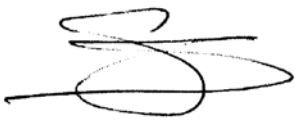
We need to ensure that the right balance is achieved between providing accessible services for patients and carers and making sure they are provided with high quality care by appropriately trained and experienced staff.

We hope that by bringing an expert clinical voice we can contribute in a positive way to the future development of the West Hertfordshire system proposals to improve the care and sustainability of services for patients in the West Hertfordshire area.

I am grateful to David Radbourne, Programme Director for the West Hertfordshire strategic review, for inviting us to undertake the review at this stage of their progress. I commend the team for their clear and helpful presentation, documentary evidence and willingness to answer our questions 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.

On behalf of the panel and the clinical senate, we look forward to seeing the next stage of development with details firmed up across the programme and particularly the detail of patient outcomes and the how.



Dr Bernard Brett
Clinical Senate Chairman

ADVICE REQUEST

2.1 In December 2014, the east of England clinical senate was approached by David Radbourne, Programme Director for the Herts Valley CCG[1] strategic review, with a view to looking at how the east of England clinical senate could provide independent clinical input on the clinical element of its case for change and planned strategic response.

2.2 The approach and clarification of the scope of the request was developed during March and April and a clinical review panel date set for 10th June 2015.

2.3 It was agreed that this clinical review panel review would be a high level peer review of the evidence and information to comment upon and make recommendations on how any gaps in that evidence or planning could be supported with further evidence and information for a full panel review later in the year.

2.4 The clinical review panel was asked to look at the early outline proposal for the provision of sustainable health and social care in West Hertfordshire, in the context of the Five Year Forward View and respond to the question:

"in the context of the case for change and developing national recommendations on care models, do the proposed models of care for the future in West Hertfordshire constitute reasonable proposals to deliver high quality care based on known evidence and good practice?"

2.5 The scope of the advice did not include the east of England clinical senate formulating or proposing any alternative options, nor did the scope of review consider any financial implications, either negative or positive.

[1] The West Hertfordshire system referred to throughout this report (as Herts Valley CCG or West Hertfordshire system) compromises of the following organisations: West Herts Valley CCG, West Hertfordshire Hospital NHS Trust, East of England Ambulance Service NHS Trust, Hertfordshire community NHS Trust, Hertfordshire Partnership University NHS Foundation Trust and Hertfordshire County Council.

2.6 The evidence and information provided for the clinical review panel was provided by Herts Valley CCG.

3. Background

3.1 The West Hertfordshire system recognised that it was already challenged in being able to consistently deliver high quality health and care services and that the challenge would become even greater in the coming years.

3.2 To assist with meeting that challenge and close some gaps, health and social care bodies in West Hertfordshire system came together and undertook a review, and developed a programme of work, 'Your Care, Your Future', for proposals for future delivery of health and care services.

3.3 'Your Care, Your Future' aims to address four key questions:

1. How well (how effectively and efficiently) are patients' needs met by the current health and social care system across West Hertfordshire?
2. What are the opportunities to meet future health and social care needs of the West Hertfordshire population more effectively and efficiently?
3. How should health and social care services across West Hertfordshire be configured to realise these opportunities? and
4. What organisational forms(s) and commissioning / contracting model(s) best support the delivery of the preferred future configuration of services?

3.4 The Your Care, Your Future approach and the above questions are in line with NHS England's Five Year Forward View[2] 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.'*

[2] NHS England, October 2014

3.5 Herts Valley CCG recognised that the programme was currently sitting somewhere between questions two and three (above) and sought the input of the East of England Clinical Senate to identify any gaps and provide any advice from a clinical perspective on moving forward to question four.

4. CLINICAL REVIEW METHODOLOGY & GOVERNANCE

4.1 The scope of the review was discussed with the Herts Valley CCG programme Director to identify the most appropriate skill mix and expertise for membership of the clinical review panel and also the approach to be taken.

4.2 It was agreed that a desktop review of the evidence by panel members followed by a single panel day with West Hertfordshire system was the most appropriate approach. It was agreed that site visits would not add any additional value or information to the evidence provided at this stage of development.

4.3 Terms of Reference for the review were drafted with the Herts Valley CCG and agreed and signed by David Radbourne, Programme Director and Dr Bernard Brett Chairman of East of England clinical senate and council appointed Chairman of this clinical review panel.

4.4 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 been invited, accepted, made declarations of interest and signed a confidentiality agreement, they were sent by email the documents and evidence provided by Herts Valley CCG as its evidence base for the panel.

4.5 A pre-panel telephone conference with panel members was held prior to 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.

4.6 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 Herts Valley CCG prior to the panel day taking place.

4.7 The clinical review panel took place between 10.00am and 4.00pm on 10th June. West Hertfordshire system gave a 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.

4.8 A draft report was circulated on 22nd June 2015 to panel members and Herts Valley CCG for matters of accuracy.

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

4.10 This report is then submitted to David Radbourne for Herts Valley CCG and remains in their ownership.

4.11 On a date agreed with Herts Valley CCG, the east of England clinical senate will publish this report on its website as agreed in the review Terms of Reference.

5 GENERAL COMMENTS

5.1 The panel commended the West Hertfordshire team on the high level of system and clinical engagement to date in the Your Care, Your Future programme. The high degree of understanding, knowledge and system intelligence of the current position and future challenges and opportunities was clear to see as was the ambition in driving this forward to achieve system wide benefits.

5.2 The direction of travel for the West Hertfordshire system was welcomed. The panel recognised investment of time and resource to the research, analysis and engagement to gain such a degree of understanding. It was evident that there was a high level of commitment and determination from across the system to meet the challenges together.

5.3 The panel was pleased to be able to offer input at this early stage of Your Care, Your future programme. The recommendations of the panel were intended to support Herts Valley CCG in areas where the panel found further detail or information would have been helpful in helping it to understand the way forward.

5.4 The panel recognised that in the limited time available on the day, it was not able to cover all aspects of the programme or its own questions and acknowledged that Herts Valley CCG had more intelligence and understanding of the programme than it was able to share on the day. However, the panel agreed that this was not detrimental in anyway to its understanding or impact upon its findings or recommendations. The panel was keen to make clear that the recommendations were intended to be supportive and not in any way critical of the huge amount of work clearly already undertaken.

5.5 The panel agreed that whilst patient outcomes were not the first key line of enquiry on the agenda for the day, it was the most fundamental element and have therefore reflected that in the order of this report.

6. Key findings & recommendations

Line of enquiry: Patient outcomes

Key findings

6.1 The panel agreed that the joined up approach of the Your Care, Your Future programme should result in benefits and improvement in the system. Some high level system outcomes had been expressed although these did not yet have measures developed. However what was not clear from the evidence and discussion were the intended benefits and improved outcomes for patients from implementation of Your Care Your Future, and how these benefits and outcomes would be measured or assessed.

6.2 The panel acknowledged that although this stage of development was too early to have defined measures, ideally the principles of what should be measured and why, should be available now for the team. This would enable Herts Valley CCG to understand how it would start to measure and demonstrate the success of the programme both of its parts and as a whole. It would also potentially allow the collection of the some baseline line data in relation to these measures.

6.3 The panel agreed that measures should be developed across the range of services, the system and parts of the system (e.g. integration, care closer to home). Most importantly, there should be measurements specifically around patient experience and the quality of services (e.g. end of life, cancer, mental health) and in addition measures of staff experience.

6.4 A key component to patients and carers experience will be the ease with which they are able to navigate the system and access the appropriate care they need. The panel expressed some concern regarding this given potential significant changes to patient pathways and locations for care delivery. The panel felt it was very important that this element was appropriately assessed. *(covered further below in Prevention line of enquiry but panel wished to specifically make a recommendation from a patient outcomes perspective).*

Recommendation 1

6.5 The Your Care Your Future programme should describe more clearly the intended benefits and improved outcomes for patients, how those benefits would be measured, why those particular measurements were chosen and when the system would expect to see those benefits and outcomes materialise. Consideration should be given to the inclusion of patient measurement and feedback, for example patient reported outcome measures (PROMS) and patient reported experiences measures (PREMS). The panel also suggested the team consider utilising the patient activation tool that assesses an individual's ability and confidence to manage their own health and healthcare. A range of outcome measurements should be selected, capturing patient experience (including confidence in the co-ordination and integration of their care and support across providing organisations) and to also include hard end points and to cover areas where there is evidence of current poor outcomes and variation. The impact on risk factor reduction should be included; in addition staff outcome measure should be developed and included.

Recommendation 2

6.6 The panel agreed that whilst it was clear that the team had used available evidence to develop high level models, this should be further developed with grounded clinical consensus to support proposals in the next phase of development.

Line of enquiry: Prevention

Key findings

6.7 The panel heard that the Your Care, Your Future models of care had been designed around the ten population groups identified from Herts Valley CCG' extensive engagement activities. From the evidence provided, the panel was clear that the Your Care Your Future model was designed to emphasise prevention and self-management – described by Herts Valley CCG as a clear 'left shift' to prevention on the lifecycle wheel.

6.8 The panel was very supportive of the focus on population prevention especially addressing key risk factors such as smoking, obesity and lack of exercise. The panel was also very supportive regarding the aims to deliver targeted prevention interventions for particularly high risk groups including secondary prevention measures. Patient education and empowerment were also important aims. As the proposals are developed, further detail regarding the delivery of these aims including the patient and public engagement strategy would be required.

6.9 The panel heard about community navigators who would be allocated to a relatively small group of frail individuals with multiple comorbidities, intended to advise patients and their carers on practical matters such as coordinating appointments and non-medical models of crisis prevention. Whilst recognising the potential, and realizing that these roles were designed as an adjunct to the system, the panel expressed some concern about patients' and carers understanding and accessibility of these community navigators, especially in cases where there was a need to look wider than a single clinical pathway. More detailed work was required on the practical elements of this model, how it would operate across boundaries and how it would guarantee improving the delivery of a safe, quality service for patients, ensuring that they were properly signposted to, and received, the right care at the right time and in the most appropriate place. As much was is feasible, the panel felt a map of services, how they interrelated and with their relevant geographical locations should be developed in as simple and clear way as possible.

6.10 The Tower Hamlets model was described demonstrating success in applying a community navigator function but the panel felt that there were significant differences in demography and geography making it difficult to understand how applicable this would be to the West Hertfordshire area. The panel recommended a community navigation model in a more similar health care system was sought and utilised to aid the development and refinement of the community navigation role.

Recommendation 3

6.11 The panel recommended that in developing the community navigator model the team give further consideration to clarifying the role through the following:

i. defining how the community navigators would be developed and applied across the system;
ii. being clear about how the community navigators would be accessed by the different patient groups, particularly vulnerable and frail patients;
iii. risk assessing and putting in place mechanisms to address the practicalities of community navigators' ability to navigate and move across and within the system themselves, being able to deal with different parts of the system for which they may not be professionally trained or equipped;
iv. assuring the governance issues associated with the matters described at iii) above have a clear line of sight and accountability;
v. ensuring there was a clear line and mechanism for professional and clinical accountability;
vi. simplifying the system from the patient perspective (*who we are, what we do, who we do it for, how and where*) and therefore simplifying the navigation process;
vii. making clear how patients with multi-morbidities access and navigate the system, ensuring they receive care that is joined up, at the right time in the right place for them, including explicit detail about choice for those at the end of life;

viii. having in place SMART performance measure to ensure that the community navigator is effective and delivering a safe, quality service for all those who need to, and do, access it; and

ix. ensuring there is absolute clarity regarding how the work of community navigators relates to that of General Practitioners, 111, Care coordinators, peer support and voluntary sector who all have a potential role in navigating the system.

x. undertaking an early evaluation of the community navigator's role.

Recommendation 4

6.12 The life cycle diagram should be reviewed to acknowledge that recovery was not the outcome for everyone and should include end of life. The panel also recommended that measures around end of life care, for the dying and carers, be included.

Recommendation 5

6.13 The panel recommended that the future models of care, particularly in the context of the shift towards prevention, should provide detail on how the system would engage and where appropriate intervene, with the wider populations who do not regularly engage with primary care.

Line of enquiry: Integration

Key findings

6.14 During discussion, and in response to questions from the panel, Herts Valley CCG made reference to a number of different 'hub' models to be located across the geography and confirmed that the hubs may each have different staffing and skill mix, as determined appropriate to meet the needs of the local population. The panel fully recognised that the development and design of the hub models was at an early stage.

6.15 The panel heard that a proof of concept model in place in Watford was 'tweaked' regularly following weekly design team meetings. The panel expressed some concern that there appeared to be little formal evaluation undertaken or assessed before changes were implemented; that there was a lack of supported evidence of what was working well and why, and what was not working so well and why. The system was not in full receipt of the knowledge it needed to provide the sound base required for planning the scaling up of the hub model and could lead to confusion for staff and users.

6.16 The panel heard that the future models of care would seek to realign primary care and clusters around populations of 50,000, including alignment of mental health and social care teams around the population. That model would need to be scaled up to reach the West Hertfordshire population of around 700,000. While the panel recognised that this was not entirely starting from a zero base, it considered this level of scaling up was highly ambitious and may well have implications, not least for staffing and skill mix.

6.17 West Hertfordshire system acknowledged that the cultural challenge associated with such a shift would take a number of years to achieve; the panel felt that clinical and social care champions needed to be developed to lead that cultural shift across the system.

6.18 The panel agreed that there needed to be more consistency in the terminology, which it felt was currently somewhat confusing with reference to different models. There needed to be more clarity on the services provided from the hubs, whether these would be the same across all hubs or different, and if so why. More clarity on the hub model and clearer differentiation of any variation in the hubs would help with the consistency. The panel felt that whilst accommodating the need for some local variation there would be clear benefits if they were as similar as possible in terms of services provided, staff groups providing the services and hours of opening. Terminology needed to be consistent and clear for everyone, particularly patients, to ensure a right first time approach to access and utilisation.

6.19 Whilst recognising that there were existing governance structures in place, the panel agreed that in moving forward, the model would benefit from more clarity around governance *per se* and clinical governance in particular.

Recommendation 6

6.20 **Community Hubs:** In moving forward with the model, the panel recommended that there be more clarity and detail around. This should include:

i. what a community hub would be, what services it would offer, to who and how;
ii. generic and or specialist services offered by the individual hubs, how would these be defined and labelled to ensure everyone understood the role and services offered by each hub;
iii. the staffing models and skill mix for the hubs. If the hubs were bespoke to local populations then the detail of how that staffing model had been derived needed to be clear (i.e. a formal formula or methodology for ascertaining skill mix and staffing);
iv. whilst recognising the potential benefits of local variation for differing populations the panel felt there would be benefits in keeping the core aspects of each hub as similar as possible.
v. early feasibility testing for the scaling up of hubs, including location; and
vi. a clear plan for roll-out programme of hub implementation, including staffing, information management systems and estates.

6.21 The panel recommended that Herts Valley CCG should undertake an evaluation of the pilot hubs and community teams and apply lessons learned into the models going forward. Herts Valley CCG might also find it beneficial to look at the lessons learned from other similar models of community / out of hospital care teams.

6.22 **Workforce:** Herts Valley CCG should undertake detailed modelling on the future workforce requirements and skill mix and develop a strategy for workforce development for the community hubs in particular, including the current and predicted availability of the proposed workforce. The panel recognised that much of the integrated community workforce would be made up from staff in currently in post with modifications to their work patterns. The panel recognised that there had already been engagement with Health Education England East (HEEE) but suggested Herts Valley engaged in further discussion with HEEE to assist with the work force modelling.

6.23 **Scaling up:** The panel recommended that Herts Valley CCG undertake a rigorous assessment and planning for scaling up the hub model across west Hertfordshire. This should include, among others, staff skill mix, availability, competencies, and training requirements (as above), hub models and location, estate (availability and cost). The team should also put in place a clear performance framework that captured patient outcomes (as recommendation 1) and effectiveness of the hubs. The assessment should include a clear risk assessment for proposed timescales and include matters such as consideration of the commissioning cycle.

Recommendation 7

6.24 With a dispersed clinical workforce model, clear line of clinical accountability was essential. Herts Valley CCG should agree and make explicit the lines for clinical and managerial accountability and leadership for staff in the community model.

Line of enquiry: 'How'

Key findings

6.25 The panel agreed that it was too early in the Your Care, Your Future work to have detail of the 'How' defined at this current time. However it considered that discussions had implicitly included some of the early 'how' detail and this had led to useful discussions that Herts Valley CCG would be able to follow up on.

6.26 The panel was satisfied that there had been patient involvement in the development so far and recommended that this level of input be developed further. Whilst having heard that the third sector had been engaged in discussion at strategic level and stakeholder meetings, the panel did have some concern about the level of input from the sector so far given that the models proposed a much greater input from the sector in delivery.

6.27 The panel considered that Herts Valley CCG might wish to look at working closer with the voluntary and community sector and consider running a small partnership pilot; this would provide Herts Valley CCG with a better understanding of the level of risk of working with the sector and how that can be addressed or mitigated.

6.28 The panel recognised the ambition of West Hertfordshire system in driving this forward but wished to offer a sense of caution to that around risks of driving such an ambitious programme too quickly and the need to have high regard for the challenge around cultural change and organisational development.

6.29 Equally the challenge around system enablers such as information and communications technology and estate should not be under-estimated and more detail and plans would be required for the next phase of work and to meet the tests of the NHS England service change assurance process.

6.30 Clinical Leadership would be vitally important both to facilitate significant system wide change and going forward to ensure the smooth working of interdisciplinary social, health and voluntary sector teams.

Recommendation 8

6.31 The panel recommended that Herts Valley CCG reconsider its ambitious timeline for implementation in order to be able to manage the inevitable a level of risk during transition of the current service provision and the intended future models of care and to ensure there was adequate resilience in the system

Recommendation 9

6.32 In order to facilitate significant system wide change including new pathways, new locations of care and new roles it was vital that appropriate clinical and social care leaders were proactively identified, developed and supported. Likewise, in order to ensure the effective functioning of complex multi-disciplinary teams, strong and supported leadership needed to be developed. The panel recognised that some work had already started in this area.

Appendix 1: Terms of Reference for the review

East of England Clinical Senate Independent clinical review panel

West Hertfordshire health & care system

'Your Care, Your Future

Working together for a healthier west Herts'

10th June 2015

Terms of Reference

West Hertfordshire System

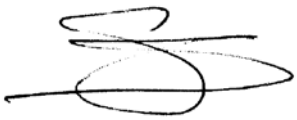
CLINICAL REVIEW: TERMS OF REFERENCE

Title: **'Your Care, Your Future, Working together for a healthier west Herts'**

Sponsoring Organisation: **West Hertfordshire health and care system**

Clinical senate: East of England

Terms of reference agreed by:



Dr Bernard Brett,

on behalf of east of England Clinical Senate and

David Radbourne, on behalf of sponsoring organisations: NHS Herts Valleys CCG, Hertfordshire Community NHS Trust, West Hertfordshire Hospitals NHS Trust, Hertfordshire Partnership University NHS Foundation Trust, Hertfordshire County Council & East of England Ambulance Service NHS Trust

Date: 9th June 2015

Clinical review team members

Dr Bernard Brett	Panel Chair Clinical Senate Chair
Philip Dale	Clinical Director, Allied Health Professionals Suffolk, Specialist (Chartered) musculoskeletal physiotherapist Clinical Senate Assembly member
Dr Julie Draper	Patient Representative, retired GP
Dr Mark Lim	Public Health representative
Dr Deepak Jain	Consultant Physician Associate Regional Advisor RCP Clinical Tutor Clinical Senate Assembly member
Sharon Murrell	Deputy Head of Midwifery & Gynaecology / Matron Supervisor of Midwives Clinical Senate Assembly member
Dr Dee Traue	Medical Director St Isobel Hospice Palliative Care Consultant, Senate council member
Professor Thida Win	Consultant Respiratory and General Medicine Physician Chair (Lung Cancer) Beds & Herts Cancer Network Clinical Director (Respiratory) EOE Strategic Clinical Network Lead (Respiratory) Eastern Academic Health Science Network Royal College Tutor (Medicine) East of England
Penny Wasahlo	Manager, Independent Living Team Farleigh Hospice Clinical Senate Assembly member

Aims and objectives of the clinical review

The review will specifically look at the early outline proposal for the provision of sustainable health and social care in West Hertfordshire, in the context of the Five Year Forward vision and respond to the question:

> **"in the context of the case for change and developing national recommendations on care models, do the proposed models of care for the future in West Hertfordshire constitute reasonable proposals to deliver high quality care based on known evidence and good practice?"**

Scope of the review

This is an early stage review of the proposal and the clinical senate review panel is being asked to support the sponsoring organisations with a high level peer review of the evidence and information. The panel is asked to review the available information and evidence, discuss, comment upon and make recommendations on how any gaps could be supported with further evidence and information for a full panel review later in the year.

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 held on 10th June 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 for fact checking prior to publication.

Comments/ correction must be received from the sponsoring organisation within **ten 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 XXXX

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 their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

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

- relevant public health data including population projections, health inequalities, specific health needs
- activity date (current and planned)
- internal and external reviews and audits,
- relevant impact assessments (e.g. equality, time assessments),
- relevant workforce information (current and planned)
- evidence of alignment with national, regional and local strategies and guidance (e.g. NHS 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

Dr Bernard Brett	Panel Chair Clinical Senate Chair
Philip Dale	Clinical Director, Allied Health Professionals Suffolk, Specialist (Chartered) musculoskeletal physiotherapist Clinical Senate Assembly member
Dr Julie Draper	Patient Representative, retired GP
Dr Mark Lim	Public Health representative
Dr Deepak Jain	Consultant Physician Associate Regional Advisor RCP Clinical Tutor Clinical Senate Assembly member
Sharon Murrell	Deputy Head of Midwifery & Gynaecology / Matron Supervisor of Midwives Clinical Senate Assembly member
Dr Dee Traue	Medical Director St Isobel Hospice Palliative Care Consultant, Senate council member
Professor Thida Win	Consultant Respiratory and General Medicine Physician Chair (Lung Cancer) Beds & Herts Cancer Network Clinical Director (Respiratory) EOE Strategic Clinical Network Lead (Respiratory) Eastern Academic Health Science Network Royal College Tutor (Medicine) East of England
Penny Wasahlo	Manager, Independent Living Team Farleigh Hospice Clinical Senate Assembly member

In attendance at the panel day

West Hertfordshire system

David Radbourne, Programme Director for the Your Care, Your Future Strategic Review

David Buckle, Medical Director for Herts Valleys CCG

Cosima Pettinicchio, Senior Manager, Consulting, Monitor Deloitte

Dr Jane Halpin, Director, Corporate Finance, Health Transactions & Restructuring Deloitte LLP

Louise Gaffney, Programme Director Whole Systems Enablers, Herts Valleys CCG

Helen Brown, Director of Transformation, West Hertfordshire Hospitals NHS Trust

David Evans, Assistant Director for Health Integration, HCC

Also attended via teleconference dial in

Dr Kevin Barrett, GP, Chair of Watford locality, Lead for the Planned and Primary Clinical Workstream (primary care, LTC, older people, out of hospital care)

Carol Gillespie, Programme Director – Integrated Care

Julie Hoare, Director of Operations, Hertfordshire Community Trust

Clinical Senate Support Team:

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

Liz Bennett, NHS England

Appendix 3: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Dr Bernard Brett	None	None	None	None
Philip Dale	None	None	None	None
Dr Julie Draper	None	None	None	None
Dr Mark Lim	None	None	None	None
Dr Deepak Jain*	None	None	None	*Declared – see below*
Sharon Murrell	None	None	None	None
Dr Dee Traue	None	None	None	None
Professor Thida Win*	None	None	None	*Declared – see below*
Penny Wasahlo	None	None	None	None

Dr Depak Jain and Professor Thida Win: Declared that they were employed in an adjacent geographical area (East Hertfordshire). The Chair and Senate Manager confirmed that this would have no influence or impact on the matter and both could remain on the panel.

Appendix 4: Key lines of enquiry

"In the context of the case for change and developing national recommendations on care models, do the proposed models of care for the future in West Hertfordshire constitute reasonable proposals to deliver high quality care based on known evidence and good practice?"

KEY LINES OF ENQUIRY

Time	**Item**
09.30 -10.15	Panel member briefing
10.20 – 10.35	Welcome, introductions and outline of panel procedure from Clinical Review Panel Chairman Dr Bernard Brett
10.40- 11.00 20 mins	Presentation and context setting for the panel from the West Herts system members (sponsoring bodies)
11.00 – 11.25 25 mins	**Questions from the panel to West Herts** Key line of enquiry - theme area 1 **'Prevention'** The panel would like to hear more about the 'Prevention' including self-management models: - how will the broader prevention aims be delivered including liaison with the educational system and broader public health agenda - How will self management be supported and in particular how will timely access to safe, quality services be assured for patients, and particularly elderly patients? - What will be provided to help navigate the system - Has the West Herts system looked at the workforce issues around the prevention and self-help models Has any modelling been undertaken on patient acuity levels and how they would be managed and brought into the prevention and self-management model

11.25 – 12.10 45 mins	**Questions from the panel to West Herts** Key line of enquiry - theme area 2 **Patient outcomes** The panel is keen to understand more about planned outcome measures: - Are any patient reported experiences of care planned and if so how will they be measured and monitored? - The panel would like clarity on whether planning for reduction in beds stays and unplanned A&E admissions is based on current activity, or predicted activity given demographic changes? - How will Mental Health outcomes be assessed? - Has system resilience been fully considered (for example in the case of a Flu pandemic)? - The level of analysis on appropriate and inappropriate admissions and how that has been factored in to the planned reduction in bed stays and unplanned admissions – is this from a patient perspective?
12.10	Themes 1 & 2 Closing comments from West Herts
12.20	Themes 1 & 2 Summary from Panel chair
12.40	Break for lunch
13.15 -14.00 45mins	**Questions from the panel to West Herts** Key line of enquiry - theme area 3 **'Integration'** The panel would like to hear more on - The community hubs, how they will operate, access for patients – how will they be staffed? - Voluntary and charity sector involvement, especially for elderly in care planning - How closer working between different providers with be delivered (eg health, social care, third sector etc) - Seamless care for end of life - Engagement with Out of hours care providers, and detail on plans for urgent care / Seven day services and out of hours care. - Arrangements for seamless transition for young people moving from CAMHS to adult mental health services - Follow up and recovery plans for mental health patients and Recovery Colleges.

14.00-14.25 25 mins	**Questions from the panel to West Herts** Key line of enquiry - theme area 4 **'How'** The panel would like to hear more detail on how the plans to ensure the system is joined up, specifically in the following areas – - Urgent care, LTC, Mental Health (adult and paedicatric) and Dementia - Recognising the national issues around health workforce, and the need to transition to new service models could West Herts provide some information on how it intends to ensure the new integrated system will be appropriately staffed and skilled to provide safe, quality care for patients? - How will appropriate high quality clinical leadership be ensured both in delivering change and in facilitating high quality multidisciplinary team working?
14.25	Themes 3&4 Integration and 'How' Closing comments from West Herts
14.35	Themes 3 &4 Integration and 'How' Summary from Panel chair
14.50	West Herts members depart. Short break for panel members
15.10 -16.30	Discussion - panel members only.

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

a) Your Care, Your Future: (Full) Interim Case for Change

b) Your Care, Your Future: Interim Case for Change Summary version

c) Your Care, Your Future: Interim Case for Change Easy Read document Spring 2015

d) Your Care, Your Future: Models in Development 26 May 2015

e) Your Care, Your Future: PEG 29th May 2015

f) Your Care, Your Future: Financial Challenge

g) Your Care, Your Future: Slide set East of England Clinical Senate 29th May 2015

Supportign document

h) Five Year Forward View (NHS England)

Document Version Control

Version	Author/s	Date	Status
0.1 draft Not for circulation	S Edwards	11.06.15	For completion post panel **Not for further or onward circulation**
V1	S Edwards	17.06.15	Draft – to BB (withdrawn by SE)
V2	S Edwards	19.06.15	Minor amendments / typos etc To BB
V3	B Brett	22.06.15	BB comments incorporated Circulated to panel members and DR for points of accuracy – to be returned by 30th June.
V4 / final	S Edwards	15.07.15	Changes ref to comments from West Herts (now referred to as Herts Valley) To BB for final check
Final	S Edwards	22.07.15	Copy provided to Herts Valley CCG caveat not yet approved by Senate Council
			Circulated to panel members and senate council for council meeting.