Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review of the Future Model of Hospital Services for Calderdale and Greater Huddersfield CCGs

December 2015

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Yorkshire and the Humber Clinical Senate
yhsenate@nhs.net

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Version Control

Document Version	Date	Comments	Drafted by
Version 0.1	6th October 2015	Compiled based on working group conversation and discussion	Joanne Poole
Version 0.2	14th October 2015	Formatting updated and revised to include working group feedback	Joanne Poole
Version 0.3	1st December 2015	Revised in response to commissioner comment	Joanne Poole
Final Version 1.0	4th December 2015	Agreed as final version following commissioner comments and Council ratification	Joanne Poole

1. Chair's Foreword

1.1 The Yorkshire and the Humber Senate welcomes the opportunity to work with commissioners on the development of their hospitals model. In its consideration of the proposals, the Senate focused on providing impartial clinical information on the sustainability of clinical services, not about the sustainability of particular institutions.

1.2 The Senate recognises the work that has gone into these proposals and fully supports the commissioners' direction of travel and their aspirations for the service. It is recognised that the detail is still to be developed and therefore we can only provide broad assurance at this stage.

2. Summary Recommendations

2.1 The Senate commends the commissioners on their vision for the future of hospital services and we support the commissioners' aspirations for the service. The Senate agrees that the Quality and Safety Case for Change and the baseline position support the need to move towards greater centralisation of services across hospital sites. The Senate agrees that a clear argument is made that the current configuration of services does not and cannot meet national guidance, and that staying the same is not an option.

2.2 The Senate recognises that the documents supplied are a work in progress and the supporting detail regarding activity and workforce will be developed as part of the pre-consultation Business Case.

2.3 As a high level strategic document for whole system change, the Senate agrees with the aspirations outlined in the Model of Care. The Senate recommends however, that as the work develops the commissioners describe the model with greater clarity, particularly focussing on detail about the workforce and activity. The lack of detail at this stage left the Senate with questions regarding the ability of this model to deliver the standards proposed. At this point, the Senate can only endorse the vision and give broad assurance of its potential to deliver a quality service. Following the receipt of further additional information about the Urgent Care Centres, the Senate are broadly content with the proposals but there is always the possibility that a very ill patient will attend the Urgent Care Centre and commissioners need to ensure that staff have the medical and nursing skills, experience and capabilities to safely stabilise that patient. Commissioners are recommended to consider this further as they develop the model.

2.4 The Senate supports the standards proposed in the documentation which are taken from a variety of national documents and reflect the best of national policy. The standards are very generic, however, and could largely apply to any Trust. Commissioners are recommended to include more detail about the level of local clinical engagement in agreeing how deliverable these standards are.

3. Background

Clinical Area

3.1 In February 2014, in response to a 2013 National Clinical Advisory Team report, Calderdale and Huddersfield Foundation Trust (CHFT), South West Yorkshire Foundation Trust (SWYFT) and Locala developed a Strategic Outline Case (SOC) for the future provision of community and hospital services in Calderdale and Greater Huddersfield and expressed a preferred configuration for future provision. The SOC

was developed by the providers into an Outline Business Case accessed by commissioners in September 2014.

3.2 Commissioners decided that they would progress changes to community services in advance of any changes to hospital services. The Senate reviewed the community proposals in March 2015. Commissioners have now developed their proposals for what the potential future model for hospital services could look like and are working with CHFT to gain broad agreement. These proposals are likely to represent significant service change.

Role of the Senate

3.3 The Senate is being approached as part of the Clinical Commissioning Group (CCG) preparation for strategic sense check 2 of the Service Change Assurance Process in order that the findings can be considered as part of the CCGs overall assessment of Readiness for Consultation.

3.4 The Senate was asked to:

Consider the hospital standards and the current baseline position, together with the potential future model of care for hospital services and provide an assessment of the extent to which they support the model's potential to deliver the hospital standards and address the issues outlined in the Quality and Safety Case for Change.

3.5 The advice will be used to inform the CCG proposals for service change, provide assurance for the quality impact assessment and form part of the submission to NHS England for the assurance stage 2 checkpoint.

Process of Review

3.6 The Senate received the request for review on the 11th August 2015 with the associated evidence. The Working Group was appointed by the end of August and the Terms of Reference were also agreed by this date.

3.7 The Senate Working Group held a number of teleconferences to aid their discussions during the final two weeks of September. Initially, a meeting was planned with commissioners for the 20th October 2015, however, an initial call was held with commissioners on the 1st October and it was agreed that a further discussion was not required. The commissioners provided further information on the Urgent Care Centres. The report was drafted by the Working Group following the receipt of this additional information and the discussions and the final draft was provided to the commissioners for comment on the 16th October 2015. The report and commissioner comments will be provided to the Senate Council for final ratification on the 19th November 2015.

4. Evidence Base

4.1 The Senate has referred to the National Institute for Health Research Report [1] to identify the evidence base. This report acknowledges that whole-hospital- and -system change is an area in which there is little robust evidence and there is much more evidence to guide change in specific service areas. The report states that more longitudinal studies are needed to track the economic and quality benefits of whole-hospital- and -system change, even though the evolving nature of service change and the lack of the necessary financial and quality information can make this difficult.[2]

4.2 The clinicians involved in this review worked to achieve a consensus based on experience and judgement. As this review considers a number of services including urgent and emergency care and maternity services, the lengthy evidence base for these specific service areas has not been repeated in this report but it is summarised in the National Institute for Health Research report[1].

5. Recommendations

General Comments

5.1 The Senate commends the commissioners on their vision for the future of hospital services. The Senate agrees that the Quality and Safety Case for Change and the baseline position support the need to move towards greater centralisation of services across hospital sites. The Senate agrees that a clear argument is made that the current configuration of services does not and cannot meet national guidance and staying the same is not an option.

5.2 The Senate fully supports the commissioners' direction of travel and their aspirations for the service. The level of detail as yet provided in the model does not clearly translate those aspirations into actions, the model proposed may result in an excellent service but the lack of detail at this stage, particularly regarding workforce, leaves the Senate with questions regarding the ability of this model to deliver the standards proposed. At this stage, the Senate can only endorse the vision and give broad assurance that this has the potential to deliver a quality service.

5.3 The Senate has separated its comments into several key areas which we hope will assist commissioners as their model develops.

[1] Insights from the Clinical Assurance of Service Reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed method study. National Institute for Health Research.
[2] Spurgeon P, Cooke M, Fulop N, Walters R, West P, 6 P, et al. Evaluating Models of Service Delivery: Reconfiguration Principles. Southampton: SDO; 2010.

The Quality and Safety Case for Change

5.4 The Senate agreed that this is a good document which outlines the proposals for change and their rationale. It clearly sets out that there are inconsistencies in outcomes for patients, a hard message to receive and give, but very necessary in gathering support for the propositions. The report states some key challenges such as mortality, re-admission rates, harm free care measures, Standardised Hospital Mortality rate, Length of Stay, long wait for diagnostics, high complaints and nurse sickness. The Senate agrees that this provides a clear, balanced and powerful message that the current configuration of services does not and cannot meet national guidance and that staying the same is not an option. Page 6 clearly highlights that Calderdale & Huddersfield NHS Foundation Trust does not consistently achieve the harm free measures of the national Patient Safety Thermometer. The Senate also agreed that the document clearly points out the variation in the quality of maternity care across the services and makes the case that they are not configured around the patients' needs. Linking this with the staffing challenge supports the case for change, as does the parents dissatisfaction on page 12 of the document.

5.5 The Senate felt that in some cases there was opportunity for greater explanation and linkage of the case for change with the proposed solutions and the prioritisation agreed by commissioners does not appear to address all of these issues outlined in the document.

5.6 The following comments may assist with the further development of the document:

5.6.1 Page 3: Commissioners may wish to consider adding more data about the over 85s. Those in this age group are the frailest, have the most complex of needs that are hugely challenging to address. In terms of integrated care, the other 2 programmes will be looking at alternatives to hospital for them – but while hospital is sometimes the only place to be, it is easy to debilitate if discharge is not optimally timed and coordinated.

5.6.2 We felt it would be helpful to have an example of the Quality and Safety dashboard, how it is going to be used and by whom and the escalation frameworks.

5.6.3 For specifics like pressure ulcer venous thromboembolism screening and falls, we could not see a clear explanation of specific measures that will resolve them. Similarly, we could not see an explanation about what is going to be done about hospitalisation rates above national average for patients with Long Term Conditions.

5.6.4 It would be helpful to provide more information to understand the driver for the 30 day re-admission rate.

5.6.5 It would be helpful to provide more information within this document of the fundamental staffing issues, the skill mix, numbers and the factors that are causing the workforce pressures. A driver for change is the ability to staff rotas and a description of difficulties in this area would strengthen the case. Commissioners may also want to consider working alongside your providers to fully understand the reasons for higher sickness absence. Higher absences often results in higher use of bank and agency staff which can impact on Trust quality measures. Commissioners will want to seek assurance that there is a plan to fully understand the reasons for this situation and that there is an action plan for recovery.

Baseline Document

5.7 To evidence the improvement in patient safety and care quality, the proposal has provided a baseline for some but not for all of the defined 26 metrics. The Senate questioned whether this means it is anticipated there will be improvement in some but not all metrics. The Senate felt that the baseline would benefit from including differences, if any, in available infrastructure and workforce on the two hospital sites together with more detail on workload volumes.

The Standards

5.8 The standards proposed in the documentation are taken from a variety of national documents and broadly, we cannot disagree with the nature of these standards which reflect the best of national policy and aim for the best service. Largely, these standards have been considered throughout the Future Model of Care document. The Senate agreed that the documentation clearly makes the case that these standards cannot be achieved under this current model of service and that change is required.

5.9 The documentation does not give a sense, however, of what local clinical discussions there have been in agreeing how achievable these standards are locally. The standards are generic and could largely apply to any Trust, which left the Senate with questions about their deliverability. From the information provided, we could not have confidence that the model would guarantee performance in the absence of clarity on the other key factors including staffing levels, which the Senate agreed are crucial to the delivery of these standards. The case for change, the model and our understanding of its ability to deliver the standards would be considerably strengthened by the inclusion of more workforce information. For example, with regards to standards 41 and 43 it would be interesting to note the compliance with senior sisters having supervisory time and senior nurses attending ward rounds. These activities are key in reducing complaints, improving patient experience and enhancing discharge processes.

5.10 There were some areas where the Senate could not clearly see how the delivery of some of these standards could be tied solely to the service change, for example, in some of the later standards around patient flow through diagnostics, including 24/7 availability of radiology, and access to lab/x-rays. As a final comment, in standard 68, commissioners may consider a next day service for tuberculosis smears as adequate.

The Hospital Model

5.11 The Future Model of Care documentation presents a more centralised model of care which the Senate fully endorses. The Senate agreed that this was a very good articulation of patient centred care. As a high level strategic document for whole system change, the Senate agrees with the aspirations outlined. The Senate felt however, that the proposed model could be described with greater clarity. Our understanding is that the Emergency Care Centre (ECC) along with all specialties required to deliver a fairly comprehensive emergency care service, will be located on one hospital site This will include acute paediatrics and an obstetric led maternity service. The co-dependencies are described. The rationale for the single emergency centre is clear. We also agreed that the maternity and children's model are clear, with sound rationale. More detail on the non-elective service that will continue to be provided on the other hospital site would be reassuring. In further presentation of the evidence, commissioners are recommended to provide a clearer picture of the current services including geography, population, patient access etc. and articulate more directly how this current model will change. How achievable these aspirations are depends on the operational detail, particularly the workforce model, including recruitment and retention. As already stated, the documentation does not articulate what the workforce challenges are and how they will be addressed.

5.12 The aim of "right care, right time right place" rightly places emphasis on community services however, more information could be provided on what role primary care (and social services) have in this plan. The Senate felt that there could be detail within the model about the integration and communication to ensure that the patient pathway is as smooth as possible. The clarity of the part played by each section of the organisation and the ease, with which a patient moves through their journey, could be better reflected here. The Senate also agreed that the links with the work on care closer to home do not come through here clearly enough.

5.13 Within the Model of Care document, more could be made of the 3 programmes and the importance of keeping them linked in the coming 2-3 years in order to bring about whole system change. Hospital staff need to understand that reducing length of stay and avoidable admissions and re-admissions depends upon collaborative working and joined up pathways. This may need to be supported by a cultural shift in thinking. On page 3, the honesty about the variability of hospital care is commendable and this could be used powerfully with clinicians in initiating new models.

5.14 It was not clear from the information provided, on the level of engagement which there has been with Primary Care. We also felt that the model could be strengthened with clear information on the link to social services and mental health services. End of life care and palliative care services need a dedicated focus and there is no mention of them in these papers.

5.15 On page 7 of the document, the Senate felt that there may be some mileage in separating frailty medicine out from the other specialties, given the opportunities to reduce length of stay and discharge from urgent/emergency settings to appropriate intermediate/care closer to home services for these patients. Interface geriatric models elsewhere have been very successful. This is a different and important work stream that needs a focus.

5.16 As a final point, the Senate noted that the documentation does not include the commissioner strategy on the supporting data and intelligence systems.

The Urgent Care Centres

5.17 There is a lack of detail within the evidence supplied about the urgent care centre model. Further discussion with commissioners confirmed the following detail on the Urgent Care Centres (UCCs):

What will be delivered by the UCC and to whom and what facilities will they have?

5.18 The Urgent Care Centre is a primary care facility with minor injuries incorporated. We would expect them to have Point of Care Testing and X-Ray facilities. In the specification it has been agreed that the centres will be medically-led by a clinician with the knowledge and skills to undertake triage and autonomous decision making regarding the next steps in an individual's care. We expect this is likely to be GP's but have to recognise current and future workforce issues. Hand over is expected to include update to the Hospital Electronic Patient Record which is available across all sites. Diagnostics would have been started and patients needing transfer will be discussed (over e.g. Skype) with the Emergency Care Centre (ECC) prior to transfer.

5.19 Patients can only get into the Emergency Care Centre via some sort of clinical triage. GPs are a valid form of triage but they are likely to send cases via ambulance. The ambulance staff / paramedics will have protocols which stratify patients so that they can direct them into the ECC depending on the acuity of their illness. Patients in the remote UCC(s) who have serious illness will be triaged, stabilised often with technology assistance (Skype) from the specialists at the ECC, and then transferred.

If there are 3 sites, will they have the same infrastructure to support care delivery (consistency)?

5.20 Yes, the aim is for a consistent offer on all 3 sites if affordable/can be staffed. The 3rd site may not be 24 hour.

What are the implications of transfer of patients between sites? Can the UCC stabilise the emergency patient whilst transport is being arranged?

5.21 Yes, Skype type technology would facilitate a discussion with the Emergency Care Centre specialist doctor so that they would be involved in management / stabilisation prior to transfer.

What is the time line for their development?

5.22 The pre-consultation Business Case is under development. As part of that, commissioners will need to determine feasibility in relation to finance and workforce for the whole model. It is expected that this will be ready for consultation early in 2016.

What is the current 'in hours GP' service and how will the current out of hours service be incorporated and negotiated?

5.23 There isn't a current GP in-hours service. Commissioners are considering Multispecialty Community Providers (MCP) / Primary and Acute Care Systems (PACS) models to deliver this in future.

What are the links to social and mental health triage and assessments?

This will be subject to more detailed future work.

5.24 This additional information has answered many of the Senate questions about these centres and we are broadly content with the proposals. In their further development, commissioners are recommended to consider:

5.24.1 The skills of the workforce. The triage skills and staff clinical portfolios need to be sufficient to enable them to make timely and informed decisions. There is always the possibility that a very ill patient will attend the Urgent Care Centre and commissioners need to ensure that staff have the medical and nursing skills, experience and capabilities to safely stabilise that patient. Currently, the Senate has no information on the staffing of these centres and an inexperienced staff member seeking advice from colleagues via Skype does not offer a rounded solution. We are also not clear on the paediatric expertise at each centre.

5.24.2 The signposting to the UCCs. The key to their success is the patient understanding of their role and commissioners need to define the capabilities of these centres. Whilst patients will understand what to expect when they visit their GP and the Emergency Department, they will need educating on what the UCCs can offer them. Patients need to determine how urgent their need is. Although there is the ability for patients to book appointments at urgent care and also to use this as a walk-in centre, this may present a confused picture to patients as to how they are supposed to use the facility.

5.24.3 Secure telemedicine links are required to provide the ability to transfer Digital Imaging and Communications in Medicine files (DICOM) easily together with other imaging and pathology data. Skype is not appropriate for this purpose.

5.24.4 Further information on how the current Out of House Service will be incorporated and negotiated would be helpful.

The Wider Context

5.25 There is work ongoing across West Yorkshire and the wider Yorkshire and the Humber geography to determine a range of service models including urgent and emergency care, stroke and vascular services. The Senate understands the need for commissioners to press ahead and meet the needs of their population and therefore, their inability to await the conclusion of these larger scale pieces of work. The outcome of this work however, will impact upon the Calderdale and Greater Huddersfield Hospital model and in discussion, commissioners gave the Senate assurance that they are fully engaged in all these work streams and that they will have the flexibility to respond to those outcomes as and when they are determined. The Senate also discussed the impact of their proposals on neighbouring services, Mid Yorkshire for example, and commissioners also gave assurance about those ongoing discussions and their understanding of the need to provide a seamless patient pathway across boundaries.

6. Summary and Conclusions

6.1 The Yorkshire and the Humber Clinical Senate concludes that:

6.1.1 The Quality and Safety Case for Change and the Baseline document demonstrate that the current configuration of services does not and cannot meet national guidance and staying the same is not an option.

6.1.2 The documentation provides a good vision for the future of hospital services and we support the commissioners' aspirations to move towards greater centralisation of services across hospital sites.

6.1.3 At this point, the Senate can only endorse the vision and give broad assurance of its potential to deliver a quality service. The proposed model needs to be described with greater clarity, particularly detail about the workforce, in order to answer questions regarding the ability of this model to deliver the standards proposed.

6.1.4 Further consideration needs to be given to the staffing of the Urgent Care Centres in order to ensure there is the correct medical and nursing skill mix and experience to safely stabilise a very sick patient.

6.1.5 The standards are understandably drawn from national documents but they are therefore very generic. The documentation would be improved with further narrative about the level of local clinical engagement there has been in agreeing how achievable these standards are locally.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Professor Chris Welsh, Senate Chair

Catherine Wright, Allied Health Professionals Lead, Bradford District Care Trust

Dr Andrew Phillips, Interim Deputy Chief Clinical Officer, Vale of York CCG

Richard Parker, Director of Nursing & Midwifery & Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dr Sewa Singh, Medical Director, Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Assembly Members

Peter Allen, Public Representative

Dr Philip McAndrew, Consultant Radiologist, Barnsley Hospital NHS Foundation Trust

Dr David Partridge, Consultant Microbiologist, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Peter Weaving, GP Clinical Director North Cumbria

Co-opted Members

Lesley Bainbridge, Strategic Lead, Older People's Services and Integrated Care, Gateshead Health Foundation Trust

Dr Mike Jones, Consultant Acute Physician and Clinical Director Unscheduled Care, Co Durham & Darlington NHS Foundation Trust

Appendix 2

PANEL AND COUNCIL MEMBERS' DECLARATION OF INTERESTS

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict	Further Comments
Steve Ollerton	CCG Chair	Greater Huddersfield CCG	12.8.14 & 20.11.14 and re-declared at September 2015 Council meeting	Chair of the CCG that will be seeking advice from the Senate	20.11.14 and restated at September 2015 Council meeting	To manage this conflict of interest we will need to ensure that Steve does not take part in any Council or sub group discussions as they relate to this matter	

Appendix 3

TERMS OF REFERENCE

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Calderdale and Greater Huddersfield CCGs Future Hospitals Model

Sponsoring Organisation: Calderdale CCG

Terms of reference agreed by: Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Matt Walsh on behalf of Calderdale CCG

Date: 28th August 2015

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Professor Chris Welsh, Senate Chair

Citizen Representative: Peter Allen

Clinical Senate Review Team Members:

Name	Job Description
Lesley Bainbridge	Strategic Lead, Older People's Services and Integrated Care, Gateshead Health Foundation Trust
Dr Mike Jones	Consultant Acute Physician and Clinical Director Unscheduled Care, Co Durham & Darlington NHS FT
Dr Philip McAndrew	Consultant Radiologist, Barnsley Hospital NHS FT
Dr David Partridge	Consultant Microbiologist, Sheffield Teaching Hospitals NHS FT
Richard Parker	Director of Nursing & Midwifery & Quality, Doncaster & Bassetlaw Hospitals NHS FT
Dr Andrew Phillips	GP & Deputy Chief Clinical Officer, Vale of York CCG
Dr Sewa Singh	Medical Director, Doncaster & Bassetlaw Hospitals NHS FT
Dr Peter Weaving	GP Clinical Director North Cumbria
Catherine Wright	Allied Health Professionals Lead, Bradford District Care Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

To consider the hospital standards and the current baseline position together with the potential future model of care for hospital services and provide an assessment of the extent to which they support the model's potential to deliver the Hospital Standards and address the issues outlined in the Quality and Safety Case for Change.

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

To provide strategic independent advice on the extent to which the CCG proposals will address the Quality and Safety Case for change and deliver the Hospital Standards.

The Senate advice will inform the Stage 2 of the assurance process by reviewing the service change proposal against the clinical evidence base key test. The findings will be considered as part of the CCGs' overall assessment of 'Readiness for consultation' and form part of the CCG submission to NHS England for the assurance stage 2 checkpoint.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 11th August 2015

Agree the Terms of Reference: Drafted 28th August 2015

Receive the evidence and distribute to review team: 11th August, review team appointed between 11th and 26th August and evidence distributed to all members during this time

Teleconferences: Working Group internal teleconferences scheduled for w/c 14th and 21st September.

Meeting with Commissioners: Teleconference scheduled 1st October

Draft report submitted to commissioners: 16th October

Commissioner Comments: 2nd November

Senate Council ratification; 19th November

Publication of the report on the website: TBC

4. REPORTING ARRANGEMENTS

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

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

1. CCG Hospital Standards;
2. CCG current Baseline against these standards
3. CCG Quality and Safety Case for change
4. The Outcomes the CCG expect the Model to deliver (also an Appendix in the model)
5. The potential Clinical Model

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

6. REPORT

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

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

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

7. COMMUNICATION AND MEDIA HANDLING

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

8. RESOURCES

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

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

9. ACCOUNTABILITY AND GOVERNANCE

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

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

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

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 4

BACKGROUND INFORMATION

The evidence received for this review is listed below:

1. CCG Hospital Standards Version 2.1

2. Calderdale and Greater Huddersfield Trust Overall Quality and Safety Template response

3. CCG Quality and Safety Case for change version 3.4

4. RCRTRP Hospital Standards Outcomes version 3.1

5. The Hospital Services Future Model of Care Version 0.9