NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review

for

Airedale, Wharfedale and

Craven CCG on the future

of Castleberg Hospital

Final Version 1.0

October 2017

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Clinical Senates are independent non statutory advisory bodies hosted by NHS England. Implementation of the guidance is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate
England.yhsenate@nhs.net

Date of Publication: October 2017

Version Control

Document Version	Date	Comments	Drafted by
Draft Version 0.1	October 2017	Initial draft report incorporating Working Group comments	J Poole
Draft Version 0.2	October 2017	Revised to incorporate Working Group comments	J Poole
Final Version 1.0	November 2017	Revised following comments at November Council meeting	J Poole

Chair's Foreword

1.1 The Yorkshire and the Humber Clinical Senate thanks Airedale, Wharfedale and Craven CCG for involving the Yorkshire and the Humber Clinical Senate in the review of the future of Castleberg Hospital. I would like to thank the expert clinicians who have worked with us on this review.

1.2 We have focused our attention on areas where we advise that commissioners could improve the presentation of their evidence and provide more information in preparation for the planned public consultation.

2. Summary of Key Recommendations

2.1 The Senate recognises that Castleberg is a centralised centre for patients that is known to the community, staff and local acute health settings and acts as a central focus of the out of hospital health pathway for patients. However, the CCG already has a comprehensive community approach to intermediate care and developing the model more in this direction is in line with national best practice and has our support.

2.2 The Senate advises that the assessment and evaluation of the options should be improved for public consultation. We also advise that there are areas where the CCG could improve the explanation of the community services model, the capacity of that service and the GP commitment to the model and give assurance to the public about the sustainability of the planned inpatient provision.

Recommendation: *Based on the evidence provided, the Senate advises that option 2, to close Castleberg Community Hospital and invest funding in providing care through an alternative care model, compares favourably against the other options presented.*

Recommendation: *In preparation for the public consultation the CCG are advised to improve the assessment and evaluation of the options to ensure that all are considered in equal depth.*

Recommendation: *To improve the description of the inpatient services to give the public assurance on the sustainability of the care home provision and the services that can be provided there.*

Recommendation: *To improve the description of the supporting community services, and its communication systems, and to use typical scenarios to help explain the services to the public.*

Recommendation: *To further evidence the community care team's current activity and expected activity and demonstrate their ability to meet that demand.*

Recommendation: *To provide assurance on the desire and capacity of GPs to support the community teams and provide support into care home settings.*

3. Background

Clinical Area

3.1 Castleberg hospital is an intermediate care facility near Settle of approximately 10 beds which flexes according to winter pressures. It was closed on a temporary basis earlier

in 2017 because of patient safety issues related to the structure of the building. A similar closure took place in 2008 and was perceived by the isolated rural community, which has affection for the facility and its services, as an attempt to close it permanently and a somewhat challenging public involvement exercise took place for the then Primary Care Trust (PCT). The facility was reopened later that year and has continued to operate since. The service is commissioned by Airedale, Wharfedale and Craven Clinical Commissioning Group (AWC CCG), provided by Airedale NHS Foundation Trust (FT) and the buildings are 'owned' by NHS Property services.

3.2 The CCG has entered a pre-consultation process on their options for the provision of intermediate care, which includes the future of Castleberg Hospital, with the subsequent consultation planned for 2017/2018. This is expected to attract a lot of community and political interest.

3.3 The CCG have stated that an independent clinical assessment of the services would add value to the consultation and the impartiality of any decisions that may be made regarding the future of the service.

Role of the Senate

3.4 The CCG asked the Senate to provide an independent clinical perspective on the options for the future of the Castleberg Community Hospital and the services provided within that facility. The Senate view will help to inform the CCG Clinical Executive Group and CCG Governing Body Committee decision making on the future provision of care.

3.5 In their discussions the Senate has focused on providing a response to the following question:

Can the Clinical Senate provide an independent clinical assessment of the option to close Castleberg Community Hospital and the services provided at that facility and provide care at home or in a community setting compared to the other options of continuing to commission an inpatient hospital facility in North Craven? What risks, issues, opportunities or concerns does the Senate advise the commissioner to consider as they reach a conclusion on their preferred option?

Process of the Review

3.6 The Terms of Reference were agreed in late July and are available at Appendix 3. The supporting documentation was received by the Senate and distributed to the Expert Working Group in early September. During September the Senate working group shared comments on the documents by email and supplemented this with 2 clinical discussions by teleconference and a teleconference with the commissioners to provide opportunity to further improve our understanding of the proposals. Once consensus was reached on the draft report it was sent to the commissioner for comment on 23rd October.

3.7 Commissioners are given 10 working days to respond with any comments on the accuracy of the report. The report is to be ratified by the Senate Council at their November meeting.

4. Evidence Base

4.1 Within the documentation the Senate received a comprehensive summary of the evidence base for Intermediate Care which we agreed was a thorough evaluation. The Senate has drawn on this summary within their evaluation of the proposals and also noted the King's Fund publication on Developing Accountable Care Systems in Canterbury New Zealand[1] which looks at integrating care across organisational boundaries and increasing investment in community-based services. Senate Council members recommended this publication to the CCG.

5. Recommendations

5.1 Our recommendations first focus on the following part of the question:

Can the Clinical Senate provide an independent clinical assessment of the option to close Castleberg Community Hospital and the services provided at that facility and provide care at home or in a community setting compared to the other options of continuing to commission an inpatient hospital facility in North Craven?

5.2 In the documentation the Senate was presented with 3 options:

Option 1: Keep Castleberg Community hospital Open. Refurbishment of the Current Castleberg Community Hospital

Option 2: Close Castleberg Community Hospital and invest funding in providing care through an alternative care model.

Option 3: Build/ Utilise an Alternative Facility

5.3 The Clinical Senate confirmed Option 2 as their preferred option for this service based on the evidence provided and the subsequent discussion with the commissioners which provided more detail on the intermediate care community services. We recognise that Castleberg is a centralised centre for patients that is known to the community, staff and local acute health settings and acts as a central focus of the out of hospital health pathway for patients. However, option 2 which sets out a model of caring for patients in their own home or a community setting, appropriately supported through community services, is in line with national best practice and has our support. The existing community integrated approach to

[1] Developing Accountable Care Systems: lessons from Canterbury New Zealand
The King's Fund, August 2017 King's Fund report

healthcare has developed around the Castleberg facility with the success of the other approaches to intermediate care already reducing the need for the bed provision.

Recommendation: Based on the evidence provided, the Senate advises that option 2, to close Castleberg Community Hospital and invest funding in providing care through an alternative care model, compares favourably against the other options presented

Our subsequent comments address the following part of the question: *What risks, issues, opportunities or concerns does the Senate advise the commissioner to consider as they reach a conclusion on their preferred option?*

Presentation of the Assessment of the Options

Equity of Assessment.

5.4. Within the documentation received Option 2 has been developed in more detail. From our discussion with commissioners we understand that this is because option 1 is essentially the no change option and option 3 only contains broad detail due to the separate work being undertaken to understand the financial viability of that option. If that work leads to the conclusion that this is not financially viable then this option will not go out to public consultation. We also understand that the public pre engagement which is currently underway may also result in further options being put forward.

5.5 The Senate understands the commissioner's position but advises that in preparation for their public consultation they ensure that all their options are equally assessed as currently there is no equity in the depth of evaluation of all 3 options. Within a full option assessment we would expect to see all options assessed against a clear set of criteria setting out how the CCG have reached their preferred option. This criteria needs to be applied equally across all the options to demonstrate the transparency of decision making with only the viable options taken to public consultation.

Utilising Patient feedback

5.6 The Senate felt that the CCG have not fully utilised the opportunities to report on the patient experience of the service since April. It is stated in Appendix F that patient satisfaction should increase with option 2 but there is no risk score associated with this option. However the patient satisfaction scoring for option 1 gives this *a* risk score of 6, the reason given that it may affect patient satisfaction as patients have limited choice. It doesn't appear that the assessments have been equally considered and the evidence base for this assessment of the risk isn't made clear.

5.7 On page 11 there is suggestion that patients and carers already had choice, and some chose alternative facilities such as care homes. If our understanding is correct this will mean that the majority still chose Castleberg Hospital but there is no analysis as to why Castleberg is still the preferred option for some patients and carers when given the choice, and how this can be mitigated with Option 2.

5.8 There is also reference in the equality statements that service users, carers and the wider public have been involved in the redesign of the service but it does not go on to explain how those comments have been used.

Evaluation of Risk

5.9 The documentation does suggest that the rehabilitation ward at Airedale Hospital may subsequently be subject to a decision which may mean it no longer functions in the same way. This uncertain future was confirmed in discussion with commissioners. The Senate understands that commissioners can only design the services on their current knowledge. The Senate was assured of the commissioner's response which confirmed that if the Airedale ward was to close the commissioners would undertake an intermediate care bed review and the closure would only take place when alternative facilities in the community were in place. The commissioners comprehensive risk assessment of the options should take this issue into account.

5.10 Within the presentation of the options it may be helpful to reflect on the stated aims of the Castleberg service ('*Rate of unnecessary A & E attendances reduce'; 'Hospital lengths of stay reduce'; Increased number of people identified as at the end of their life dying in their preferred place of care)* and set out how these outcomes are met by the alternative options.

Recommendation: In preparation for the public consultation the CCG are advised to improve the assessment and evaluation of the options to ensure that all are considered in equal depth

On reading through the documentation the Senate panel raised a number of questions with regard to the enhanced community model for intermediate care. Many of these were addressed through commissioner discussions and our understanding of these issues, together with our recommendations, are set out below:

The Inpatient Services

Access

5.12 The panel raised concerns about the geographical distances between the bed-based intermediate care at the Castleberg facility and the alternatives of Airedale Hospital and the Care Home beds. The Senate questioned how accessible inpatient services would be, particularly for North Craven patients, who made up 40% of the admissions to Castleberg.

5.13 The Senate understands that the North Craven population will access their inpatient care in care homes at Ashfield in Skipton, Neville House in Gargrave or Limestone View in Settle and are unlikely to access similar level intermediate care services at Airedale Hospital. There are still long distances to some of these facilities for the rural North Craven population where local public transport is infrequent and expensive. There will always be challenges when serving such a rural population and the Castleberg facility itself is remote from public transport facilities. The Senate was assured that the CCG recognises the need for excellent 24/7 intermediate care services in the community to support this frail and elderly population.

The Availability of Beds in Care Homes

5.14 The Senate panel was supportive of the proposal to utilise beds in nursing homes, which is already an established practice in this area, but raised a number of questions about the availability of those beds and also the support to patients in those beds.

5.15 The Senate notes that approximately two thirds of patients who are admitted to Castleberg are discharged from Airedale General Hospital and the new model will need to ensure the step down facilities are available so that patients can be discharged when they are ready. Similarly where there is no capacity in the care homes patients will have to travel to Airedale with all the associated challenges. Many care homes are under financial pressure across the country with a number of closures of services and although the modelling supports the current bed availability the Senate questioned the longer term sustainability of these services.

5.16 In discussion the CCG confirmed that the care home beds are ring fenced for this service and are not means tested. The CCG confirmed their assessment that there is the capacity within these care homes to manage the demand if the Castleberg facility was to close, supported by their option to spot purchase beds. The documents include population forecasting by public health which show that the CCG have considered changing demographics when looking at their options. There is some inconsistency however in the average length of stay figures in the documentation and the use of mean calculation is of limited help in some of these calculations. The CCG may wish to consider other calculations (median and inter quartile range for example) to further define the figures as it is fundamental to the proposals to have confidence in the anticipated demand.

The Provision of Services into Care Home Beds

5.17 The Senate panel raised a number of questions about the care home provision that are not explained within the documentation. These include:

i. The provision of therapy for patients requiring specialist equipment
ii. The admission criteria
iii. The numbers of patients supported in local care homes who are then transferred acutely to Airedale (i.e. repatriated following step-up or step-down) because of clinical deterioration
iv. The availability locally of carers to provide a rapid response i.e. to support a sudden increased care package
v. The out of hours support for patients in care homes
vi. The availability of rapid response paramedic or nurse practitioners to support patients during crises out of hours

5.18 Commissioners confirmed that there is already an established practice of services stepping in to care homes, including therapy teams, with out of hours support through the district nursing team. We also discussed the collaborative care team which provide the leadership for the community services supporting the care home provision. The additional information provided by the commissioners in our discussion assured the panel that the questions we raised are addressed within the service plans.

Recommendation: To improve the description of the inpatient services to give the public assurance on the sustainability of the care home provision and the services that can be provided there.

The Community Integrated Services

The Model

5.19 The evidence summary provides a good evaluation of the evidence internationally around the provision of intermediate care and clearly identifies important features like flexibility, 24/7 access, general accessibility, multi-professional and multi-agency working, which are all important in delivering good intermediate care. It would appear that AW&C CCG are delivering already on all these features with their integrated approach with a good CQC rating for the service.

5.20 We recognise that the CCG already has a well-developed use of integrated multi-professional groups working through an integrated hub. The Senate recognises the excellent reputation of the award winning community collaborative team which operates a very effective 24 /7 service offering a holistic assessment of patients and managing complex patients both in the intermediate care beds and at home.

5.21 The telehealth system is already well developed and has been commissioned outside of AW&C because of its reputation. The rurality of this area and the limited public transport has acted as a driver for the development of novel alternatives in delivering effective, quality care. We discussed the challenges of the Airedale telemedicine software (Medicare) working as effectively in rural patient's homes where the broadband and mobile reception is poor.

5.22 The Senate welcomed the additional discussion with commissioners on the supporting community services and recommends that the description of these services is improved within the presentation of the options. Providing a range of typical scenarios in the public consultation will help to describe the service in the eyes of a patient and explain to the public how the community services will offer the 24/7 integrated support.

5.23 There is little mention within the documentation about the integrated health communication system across all the involved health groups and how results and patient outcomes are communicated. The Senate panel agreed that this information should be included within the description of option 2.

Recommendation: To improve the description of the supporting community services and its communication systems and to use typical scenarios to help explain the services to the public.

The Capacity

5.24 In Option 2 patients will be geographically spread across a large area and from the documentation supplied the Senate was unable to get a sense of the existing community service's ability to cope with the increased workload or what additional community resources will be put in place to support the Castleberg closure in option 2. Our lay members questioned whether there was a full complement of staff in the new model and the resilience

of that team to cope with sickness and annual leave. It is also not clear how the skills of the integrated team surrounding the hospital are being redeployed in the new model.

5.25 The model relies heavily on the service provision of primary care and the 3rd sector without comment of the long term impact on them or their sustainability. Today services can cope but there is no comment on the ability of those services to manage the demand in the longer term and still provide that personal time and support to patients. There is also no discussion about managing the peaks in the demand over the winter season. The documentation also doesn't contain any feedback from staff currently working within this service. The perspective of those staff delivering the services should be considered within the evaluation of the option.

5.26 In discussion the CCG were confident that the required community care and support is available for patients to be cared for in their own homes regardless of location. Commissioners also confirmed that they are not predicting any additional demand over the winter months and that their model can flex according to need.

5.27 The necessity to close Castleberg has allowed the testing of option 2 but this period of closure has happened through the summer when the pressure for beds in nursing homes and hospitals is generally at its lowest. The Senate panel members, based on their experience of clinical practice, felt that the demand over the winter season would peak and that it would be helpful to see more information about the team's capacity to meet that need.

Recommendation: to further evidence the community care team's current activity and expected activity and demonstrate their ability to meet that demand.

5.28 There is a comment about the possible need to look at GP funded additional sessions to support the community teams but there is little detail here. It would be helpful to understand further the impact of this and whether conversations have been held to establish if Primary Care has the desire and capacity going forward, to deliver on this. Senate members did comment on how the proposals do recognise the need to move away from the more traditional workforce roles and increase flexibility and reduce duplication in the rest of the integrated community teams.

5.29 The Senate questioned the level of local GP support for providing support into care homes situated across the area as this could increase workload in relation to travelling. Our assumption is that the responsibility to provide GP support into the care home beds will be shared amongst the practices local to those care homes with Service Level Agreement (SLA) payment based on their level of input. In this way the burden would be spread for GPs and ideally the patients would remain under their registered GP, with all the advantages that brings, in a nursing home bed closer to their home. Again it would be helpful to understand the GP willingness and commitment to deliver on this model as it is key to its success.

Recommendation: to provide assurance on the desire and capacity of GPs to support the community teams and provide support into care home settings.

End of Life Care

5.30 Castleberg admits and cares for approximately 1 patient requiring end of life care per month, with the majority of these admissions being stepped up from the community. The Senate questioned how these patients will be supported in the new model. In discussion the commissioners provided more detail of their gold line service and their arrangement with Sue Ryder, their hospice provider, who will provide outpatient and specialist palliative care appointments through their teams based at Hospice's in Oxenhope and Lancaster. Commissioners expressed confidence in their ability to provide good quality end of life care in a timely manner.

The relationship with delirium and dementia services

5.31 In discussion with commissioners it was confirmed that Ashfield in Skipton is a dementia nursing home. It was noted that Castleberg is not used for dementia/ delirium patients.

6. Summary and Conclusions

6.1 The evidence summary provides a good evaluation of the evidence internationally around the provision of intermediate care and clearly identifies important features like flexibility, 24/7 access, general accessibility, multi-professional and multi-agency working, which are all important in delivering good intermediate care. It would appear that AW&C CCG are delivering already on many of these features with their integrated approach.

6.2 The option to close Castleberg hospital and enhance the care at home and community provision builds upon the strong community intermediate care services already in place. This option compares favourably with the other options presented.

6.3 The assessment and evaluation of the options, however, should be improved for public consultation. We also advise that there are areas where the CCG could improve the explanation of the community services model, the capacity of that service and the GP commitment to the model, and give assurance to the public about the sustainability of the planned inpatient provision.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Mr Jon Ausobsky, Consultant General Surgeon, Bradford Teaching Hospitals NHS Foundation Trust

Rebecca Bentley, Nursing Professional & Non-Medical Prescribing Lead, Bradford District Care Trust

Assembly Members

Sue Cash, Citizen representative

Beverley Foster, Radiography Lecturer, University of Bradford

David Ita, Citizen representative

Dr Rod Kersh, Consultant Physician & Geriatrician, Y&H Clinical Advisor for Dementia, Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dr Louise Merriman, GP Cancer Lead, North Derbyshire CCG

Dr Tolulope Olusoga, Consultant Psychiatrist for Older Adults & Senior Clinical Director, Tees, Esk and Wear Valleys NHS Foundation Trust

Dr Heshan Panditaratne, Consultant Radiologist, Calderdale & Huddersfield NHS Foundation Trust

Margaret Wilkinson. Citizen representative

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Bev Foster	Radiography Lecturer	University of Bradford	07.09.17	I am currently on secondment as a senior lecturer in radiography. I have been on this secondment for more than 3 years. However, Bradford University pays Airedale NHS Trust my salary for the secondment and Airedale NHS Trust is the local trust to Castleberg.'	30.9.17	Bev Foster does not work at Airedale and her employment is with Bradford University with no managerial or HR management through Airedale Trust. Bev has no financial interest in the service and is unable to provide any unfair advantage to any parties. It has been agreed that Bev can participate in this review with the conflict of interest noted. Bev will abide by the confidentiality agreement and not disclose any information to parties outside of the Working Group.

Appendix 3

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Review of Castleberg Hospital on behalf of Airedale, Wharfedale and Craven CCG

Sponsoring Organisation: Airedale, Wharfedale and Craven CCG

Terms of reference agreed by: Colin Renwick, Airedale, Wharfedale and Craven (AWC) CCG and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate

Date: 5th July

---

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Mr Jon Ausobsky, Consultant General Surgeon, Bradford Teaching Hospitals NHS Foundation Trust

Citizen Representative: Theresa Stearn, David Ita, Sue Cash, Margaret Wilkinson

Clinical Senate Review Team Members:

Dr Heshan Panditaratne, Consultant Radiologist, Calderdale & Huddersfield NHS Foundation Trust

Beverley Foster, Radiography Lecturer, University of Bradford

Dr Rod Kersh, Consultant Physician & Geriatrician, Y&H Clinical Advisor for Dementia, Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dr Tolulope Olusoga, Consultant Psychiatrist for Older Adults & Senior Clinical Director, Tees, Esk and Wear Valleys NHS Foundation Trust

Dr Louise Merriman, GP Cancer Lead, North Derbyshire CCG

Rebecca Bentley, Nursing Professional & Non-Medical Prescribing Lead, Bradford District Care Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Can the Clinical Senate provide an independent clinical assessment of the option to close Castleberg Community Hospital and the services provided at that facility and provide care at home or in a community setting compared to the other options of continuing to commission an inpatient hospital facility in North Craven? What risks, issues, opportunities or concerns does the Senate advise the commissioner to consider as they reach a conclusion on their preferred option?

Objectives of the clinical review (from the information provided by the commissioning sponsor): To provide an independent clinical perspective on the options for the future of the Castleberg Community Hospital and the services provided to inform the CCG Clinical

Executive Group and CCG Governing Body Committee decision making on the future provision of care.

Scope of the review: The Senate review will consider the options presented by the CCG and base their assessment on the documentation provided to support those options. The panel understanding of the documentation will be supplemented by clinical discussion with the CCG. In their discussions the Senate will focus on providing a response to the question asked.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: NA

Agree the Terms of Reference: end July

Receive the evidence and distribute to review team early September 2017

Early Senate Council discussion: 18th September 2017

Teleconferences: TBC. Senate panel internal teleconference mid to late September and teleconference between the panel and CCG end September to early October.

Draft report submitted to commissioners: mid – end October

Commissioner Comments Received: within 10 working days of receiving the draft

Senate Council ratification; TBC

Final report agreed: TBC

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:

- Intermediate Care in Craven, North Yorkshire. Clinical Senate submission
- Appendix A – Evidence Review
- Appendix Ai – Evidence Base for Intermediate Care
- Appendix B - Intermediate Care Need AWC

- Appendix C - Service specification for Castleberg
- Appendix D- Castleberg Summary Information Data
- Appendix E -Impact Assessments for Option 1
- Appendix F -Impact Assessments for Option 2
- Appendix G - Impact Assessment for Option 3

The review team will review the evidence within this document 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 nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 4

EVIDENCE PROVIDED FOR THE REVIEW

The CCG provided the following documentation to the Senate for consideration:

- Intermediate Care in Craven, North Yorkshire. Clinical Senate submission
- Appendix A – Evidence Review
- Appendix Ai – Evidence Base for Intermediate Care
- Appendix B - Intermediate Care Need AWC
- Appendix C - Service specification for Castleberg
- Appendix D- Castleberg Summary Information Data
- Appendix E -Impact Assessments for Option 1
- Appendix F -Impact Assessments for Option 2
- Appendix G - Impact Assessment for Option 3