

Clinical Senate Review of Community Services Specifications

for Calderdale, Greater Huddersfield and North Kirklees CCGs

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.

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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	23 rd January 2015	Compiled from working group comments	J Poole
Version 0.2	27 th January 2015	Amended from working group comments	J Poole
Version 0.3	7 th April 2015	Following commissioner comments and discussion at March Council meeting	J Poole
Version 0.4	20 th April 2015	Paragraph re-phrased following commissioner comment. Agreed by Chair in absence of Senate Council meeting	J Poole
Version 1.0	24 th April 2015	Final version	J Poole

1. Chair's Foreword

The Senate thanks the CCGs for the opportunity to review these proposals on the development of their community services. Following a review of the evidence, the Senate agrees that these proposals have the potential to result in excellent patient care closer to home and we are fully supportive of the values and principles within these documents.

The Senate did find it very challenging to meet our brief. We have raised questions for consideration within this report which we hope will be of assistance to commissioners in both developing the detail with providers and evaluating the providers' tender proposals.

2. Summary Recommendations

- 2.1 The Senate commends the CCGs on their vision for the future of their community services and agree that this has the potential to result in excellent patient care closer to home. In general terms, the Senate review group was very supportive of these comprehensive documents and their values and principles for delivering care closer to home.
- 2.2 The Senate was given a specific brief in relation to whether particular risks are addressed within the proposals and to appraise whether there are any missed opportunities within the proposed scope of services. The Senate did find it very challenging to assess the risks associated with the service transformation and we have raised a number of questions in relation to the risks arising from the lack of detail regarding workforce, primary care strategy and engagement with partners, for example. We recognise that there have been extensive discussions with stakeholders during the last 2 years which was not detailed within the evidence provided, and that the detail behind the vision will be worked through in competitive dialogue. The Senate hopes that these questions assist with that procurement process. The Senate recommends that commissioners work in partnership with the providers around the development of the service models. This shared approach to the service model development is particularly important in a system undergoing such a large level of change to help mitigate against the risks to service delivery.
- 2.3 The Senate Review Group has considered the scope of services and agrees that these are comprehensive, with little that could be considered a missed opportunity.

3. Background

Clinical Area

- 3.1 Over the past two years, 7 partner organisations across Calderdale and Greater Huddersfield have been working together to develop a vision and approach to innovate and transform services within the health and social care system.
- 3.2 Greater Huddersfield, North Kirklees and Calderdale CCGs developed a set of proposals for how they would wish to configure and deliver community services in the future. In summary, this proposes a new model for the provision of hospital and community services that comprises integrated teams of health and social care professionals working together in localities to deliver care and support in community settings. The community reforms are in the context of a reconfiguration of hospital based services. There is a provider view on what the reconfigured hospital model could look like, at the time of writing the report the commissioner views on the future model for hospital services were still under development.

3.3 The evidence considered in this Senate report is limited to the community specifications and associated documents and does not consider the reconfiguration of hospital based services. The outline business case for the reconfiguration of hospital based services was not available for the Senate to review at the same time as the community proposals. The Senate therefore advised commissioners of our intention to develop a separate working group for the hospital based services work but with a significant amount of membership overlap with the working group reviewing the community services proposals to ensure the Senate has an understanding of the integrated services across the whole patch. This report therefore, forms the first of 2 reports, this first report focusing on the community specifications, the second report reviewing the proposals for the hospital services, when this is made available. The latter report will take note within it of its fit with the proposed community service.

The Senate Role

3.4 The Senate was approached by commissioners in advance of the formal assurance processes. The commissioners wished to ensure that the Senate had the opportunity to review documentation and to understand the various factors at play, which make this change programme challenging, before the commissioners require evaluation against the 'four tests' by NHS England as part of the major service change assurance process. The advice from the Senate will therefore be used by the commissioners to inform their proposals for service change and their quality impact assessment.

3.5 The Senate received the documentation listed in Appendix 4 in early November 2014 and agreed the terms of reference for this piece of work with the commissioners in mid-December 2014, following further discussion at the Senate Council meeting in November and teleconferences with the commissioning leads. The Senate Working Group was appointed in early December, with an agreed date of the end of January 2015 for the production of the Senate report.

3.6 In the review of the community services specifications, the Yorkshire and the Humber Clinical Senate was asked:

- To consider if the following list of risks are recognised in the proposals and the extent to which the proposals within the specification will mitigate the risks
- To appraise the proposed scope of services and consider if there are any missed opportunities

Risk Id	Principal Risk
HSPB 2	There is a risk that there will be some deterioration in quality of service from the hospital due to the Trust not being able to address the workforce and service configuration issues, resulting in current workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate.
HSPB 13	There is a risk that the whole systems approach is compromised due to insufficient capacity and capability to complete and deliver the Primary Care Strategy resulting in a disconnect between primary care medical services and the vision and outcomes for the programme.
HSPB 15 CC2H r5	There is a risk of lack of clinical workforce and skills to deliver the services due to inadequate resource, resulting in delays and/or issues with implementation of the programme
CC2H 16	There is a risk that lack of information sharing will delay plans resulting in the community changes not being implemented
CC2H 27 CC2H r4	There is a risk that we do not deliver coordinated change across hospital and community services at sufficient pace and scale to address the significant quality, finance and workforce issues in our case for change, resulting in poor services being established/maintained
CC2H r16	There is risk that the agreed outcomes in the overarching specification are not achieved which would result in the original vision for care closer to home and the identified benefits for patients across the local health and social care system not being realised
CC2H r17	There is a risk that a seamless service for patients will not be realised as a result of this work due to the number of organisations / providers involved in delivering services locally which could result in the vision and outcomes for care closer to home not being realised

- 3.7 The Senate Working Group held a teleconference on 13th January 2015 to discuss their emerging thoughts and a teleconference with commissioners on 21st January 2015 which provided opportunity for the Senate to discuss the challenges they were facing in completing this work and for commissioners to explain the complexity of this work amongst the 2 year journey on the strategic services review.

4. Recommendations

General Comments

- 4.1 Overall, the Senate commends the CCGs on their vision for the future of their community services and agree that this has the potential to result in excellent patient care closer to home. In general terms, the Senate review group was very supportive of these comprehensive documents and their values and principles for delivering care closer to home.
- 4.2 The Senate was given a specific brief in relation to whether particular risks are addressed within the proposals and to appraise the proposed scope of services and consider if there are any missed opportunities within these. The Senate did find it very challenging to meet our brief due to the visionary nature of the documents. The Senate recognises, however, that the commissioners will be going into a competitive dialogue process during the tender and therefore much of the detail behind the vision will be developed during that process.
- 4.3 The Senate would have found it helpful to have more information on the primary care strategy, the services and activity that is currently delivered, the demographics, and further detail on the discussions with staff and their willingness to work in the ways proposed. Without the demographic and background information about the referral rates and demands in the current system, it was harder to review the proposed functions and capacity of the new system and the risks associated with the service transformation.
- 4.4 The request for additional background information was discussed with commissioners in the teleconference on the 21st January 2015 but the procurement timescales demanded a pragmatic approach to these gaps in the Senate understanding. In line with the commissioners preferred approach, the Senate has phrased this report to be of assistance to commissioners in both developing the detail with providers and evaluating the providers' tender proposals.
- 4.5 The Senate recommends that commissioners work in partnership with the providers around the development of the service models and not to provide that responsibility solely to the provider. This shared approach to the service model development is particularly important in a system undergoing such a large level of change, to help mitigate against the risks to service delivery.
- 4.6 The Senate has not considered the funding for these proposals and whether the care closer to home vision is achievable financially.
- 4.7 The 2015/16 planning guidance was published during this review which announced further funding opportunities for working with primary care and health and social care. The Senate is aware that commissioners are under discussion with the Local Authorities to potentially refresh some of their proposals in light of this new opportunity.

4.8 The Senate was asked to consider North Kirklees, Greater Huddersfield and Calderdale CCGs specifications and the Senate recognised that there is a shared vision across the 3 CCGs although the mode of delivery may be different to take into account the differing needs of the populations. The commissioners may want to further consider the differences in interpretation of that vision and how this may impact on the delivery of services across boundaries. One such example is the difference in approach to the services being considered for children and young people. The Senate has structured its comments broadly to cover themes across the 3 CCGs. If the Senate was approached for any further consultation it may be preferable to consider the CCGs separately to take into account the differing approaches to achieving the vision and differing procurement processes.

Specified Risks

4.9 One overall comment in relation to these risks is that commissioners may wish to consider breaking down the following list of specified risks into smaller components to help clarify the management of those risks during your dialogue process.

Risk Id	Principal Risk
<p>HSPB 2</p> <p>Comment:</p>	<p>There is a risk that there will be some deterioration in quality of service from the hospital due to the Trust not being able to address the workforce and service configuration issues, resulting in current workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate.</p> <p>The Senate found it difficult to comment on this risk as the workforce detail is to be worked through in procurement discussions. The Senate review group considered it likely that there would be workforce issues during such a large scale transformation and is aware from discussion with commissioners of the extensive engagement with staff during the previous 2 years. Evidence of this engagement was not available within the documentation received which restricted the Senate ability to anticipate the workforce issues that may be encountered.</p> <p>Commissioners may wish to discuss further with providers how the risks to patient care can be mitigated during the transition period because of hospital and community staff unfamiliarity with roles and services and with staff attachment to historical systems and roles. Providers will also need to consider how to ensure alignment between established hospital systems and the new community services.</p>
<p>HSPB 13</p> <p>Comment:</p>	<p>There is a risk that the whole systems approach is compromised due to insufficient capacity and capability to complete and deliver the Primary Care Strategy resulting in a disconnect between primary care medical services and the vision and outcomes for the programme.</p> <p>This has been difficult to comment in any detail without seeing the primary care strategy. From the information we have been given, the link between the</p>

	<p>community services and the primary care system is under-addressed in terms of relationships and interactions. Support from the GP's will be essential to success; the view expressed in the consultation that one size doesn't fit all may be a concern for commissioners as to enable the model to work the hubs have to be similar in order to allow for consistent signposting and referral of patients.</p> <p>Commissioners will be aware that resistance and refusal to change in primary care is a risk that will need addressing and therefore they may wish to give further consideration to the culture change in the relationship between primary care and community services and how they will assist in the development of a new culture. Commissioners will wish to avoid the inter-service conflict which will result in demoralised workforce and add to workforce recruitment and retention problems.</p>
<p>HSPB 15 CC2H r5</p> <p>Comment:</p>	<p>There is a risk of lack of clinical workforce and skills to deliver the services due to inadequate resource, resulting in delays and/or issues with implementation of the programme</p> <p>The Senate understands that CCG's are expecting the contracted provider to deal with the workforce issues and it was not clear within the specifications how many additional staff would need to be recruited or whether the staff currently working in primary and secondary care are adequate for the service reconfiguration. Re- assigning staff from secondary care to community services will require a transition period for retraining and orientation. If the providers need to attract new skills, there is no detail of whether the staff are available regionally or nationally.</p> <p>Within the dialogue with providers, commissioners will wish to consider who would do the triaging of the whole system, which is likely to be beyond the remit of one speciality, and how the staff would be trained to deliver that. Commissioners will also need to discuss how the staff would be moved around to provide 24 hour care for some of the specialities.</p> <p>Workforce within the local health community is likely to be fairly static in the current economic climate. Most of the staff in the new system will be current staff in the older system. The challenge will be in re-orientating the staff and getting the right skills, at the right level, in the right place within the wider system. This may need some joint working between the CCG and organisations involved. Commissioners will wish to develop the models on the services and outcomes required rather than old staffing models and ways of working. The workforce plan needs to be developed around skills rather than professions, to give greater flexibility.</p> <p>Commissioners will also want to build in some assurances about quality of staff and staff turnover to try and ensure a consistent service for patients. If statutory services are expected to provide training to non-statutory organizations, this will need factoring in to the staffing and funding models.</p> <p>The consequences of the lack of clinical workforce and skills mentioned above will not just be delays and/or issues with implementation of the programme but also a poorer service to patients. Commissioners will want to ensure that they have plans to manage the risks of a deterioration in service to patients during the implementation of the new services.</p>

<p>CC2H 16</p> <p>Comment:</p>	<p>There is a risk that lack of information sharing will delay plans, resulting in the community changes not being implemented</p> <p>Liaison with specialist services to ensure a co-ordinated approach is the key to delivering this ambitious service model. Commissioners need to ensure that they maintain that dialogue with their key partners, including local authorities to ensure they are fully behind the proposals. It is not clear from the specifications how commissioners intend to achieve the integration of the data across the services, including social services and mental health systems, and the timescales for achieving this integration. It was also not clear if there is a vision for new technologies to assist with the seamless transfer of data across organisations.</p>
<p>CC2H 27 CC2H r4</p> <p>Comment:</p>	<p>There is a risk that we do not deliver coordinated change across hospital and community services at sufficient pace and scale to address the significant quality, finance and workforce issues in our case for change, resulting in poor services being established/maintained</p> <p>The pace and scale of the intended developments is an important consideration in the assessment of risk. The Senate Review Group had some discussion with commissioners on the timescale and understands that there is to be a phased approach to balance, manage and mitigate the risks in the current system and the risks during the transition. The Senate advises that this risk needs to be further quantified against the key delivery milestones so that commissioners are clear about their achievements and have contingency plans in place if the pace slips.</p>
<p>CC2H r16</p> <p>Comment:</p>	<p>There is risk that the agreed outcomes in the overarching specification are not achieved, which would result in the original vision for care closer to home and the identified benefits for patients across the local health and social care system not being realised</p> <p>This risk is mitigated if HSPB 2, HSPB13, HSPB 15, CC2H 27 risks are addressed. The Senate review group was not clear if this risk was more concerned with setting outcomes that are unachievable within the vision or whether this is more concerned with failure of the provider to deliver</p>
<p>CC2H r17</p> <p>Comment:</p>	<p>There is a risk that a seamless service for patients will not be realised as a result of this work due to the number of organisations / providers involved in delivering services locally which could result in the vision and outcomes for care closer to home not being realised</p> <p>Fractured delivery of care to patients would reflect a commissioning failure. This risk is largely dependent on the number of organisations that commissioners contract with and the commissioners' ability to monitor the delivery of such a complex integrated system. This can be mitigated through the approach to the contracting arrangements and ensuring that commissioners contract for integration rather than with a diversity of providers.</p> <p>Where there are multi-agency teams, there needs to be agreement that they all work to the same policies rather than separate organizational policies. Particular examples of where this causes problems are in risk assessment, moving & handling, information governance standards and care management/coordination.</p>

Consideration of Other Risks

- 4.10 Commissioners may wish to consider identifying a risk regarding the role and engagement of their partners including Local Authorities. In discussion with commissioners the Senate has been informed of the engagement with all stakeholders including the extensive joint working with Local Authority and secondary care providers. The documents do not detail how these stakeholders have been actively involved in shaping this model and it would have been helpful to understand further how this relationship has been approached. The success of the care closer to home philosophy is dependent on social care involvement and funding at the patient level. Delay of this component of care may undermine the whole care package with knock-on effects through the system. Commissioners may feel that this risk has already been recognised and accounted for through other means.

Missed Opportunities

- 4.11 The Senate Review Group has considered the scope of services and agrees that these are comprehensive with little that could be considered a missed opportunity. The difference in approach to the services for Children and Young People has been highlighted in this report. The specific comments below do make some reference to wheelchair services for example but generally the Senate felt that these documents were extremely comprehensive in terms of the scope.

Specific Comments

Palliative and End of Life Care

- 4.12 The specifications cover all aspects of palliative care at a high level. In discussing the detail with providers, commissioners may wish to discuss in more detail the role and responsibility of the end of life care coordinator and the processes for delivering end of life care in the community as this was not clear within the specifications.

Older People

- 4.13 There is much mention of frailty and specialist comprehensive geriatric assessment within the documents but no mention specifically of consultant geriatric provision in the documents. Commissioners may want to discuss this further with providers and given the difficulties in recruiting consultants this will potentially pose a risk to the provision of a joined up service.
- 4.14 **Page 39 Calderdale Care Closer to Home Schedule 2 Service Specification Document Comments;** Commissioners may wish to consider the following points in their service lines included in phase 1
- If vision screening includes diabetic retinal screening
 - Under the therapies section it may be more beneficial to list the specific interventions rather than the profession
 - The review group questioned whether community equipment supplies needed to fit in these service lines as it will be a key enabler in keeping people at home

- 4.15 **Page 47 point 4;** The KPI for reduced health inequalities includes many variables in the way it is written which would preclude tying this to a particular provider performance. Commissioners may wish to consider rephrasing this into a more measurable indicator.
- 4.16 **Page 48 point 6;** There is reference to a matron lead for vulnerable groups but commissioners may wish to consider extending this beyond a nursing role as other Health Care Professionals will have the ability to undertake this lead role.

Greater Huddersfield Care Closer to Home Services Document Comments

- 4.17 **Page 11;** The specification states that the calls will be triaged by a Single Point of Access (SPA) then transferred to an **Access and Co-ordination hub** within each locality. This Access and Co-ordination hub will be staffed by co-ordinators who will have intimate knowledge of services and functions within their locality. Commissioners may want to consider in further detail, in the dialogue process, the level of health knowledge available in the triage process.
- 4.18 **Page 12;** The rapid response function description refers to this being delivered primarily by Advanced Nurse Practitioners, therapists or social care professionals where appropriate, who will also be **'trusted assessors'** and able to provide defined packages of social care. Commissioners may want to consider the definition and expectation of 'therapist', whether this includes Speech and Language Therapists, podiatry, dietetics and how the shortages of specific therapy skills will be managed.
- 4.19 **Page 13;** The core staff for Supported Transfer Function will include clinicians, therapists and social care professionals who will liaise directly with the hospital's discharge teams to ensure smooth and safe discharges into the community. Commissioners may wish to consider where the equipment store, Aids & Adaptations and the wheelchair service fits into this function.
- 4.20 **Page 14;** In the longer term care model it states that the community staff will have the added support and advice from the access and co-ordination hub and ready access to senior clinical experience and expertise within each locality. Commissioners may wish to flesh out the access to this expertise in more detail with providers.
- 4.21 **Page 16;** The description of the specialist input states that some specialist teams such as mental health are outside the scope of this redesign but it is intended that they seamlessly work with Care Closer to Home services and make use of the access and co-ordination hubs wherever possible to deliver the best care for patients. Commissioners may wish to consider further how the mental health teams will link with this system, bearing in mind that they cover a significantly larger area than the CCG, and how this discussion will be approached with mental health providers. This discussion also needs to consider how the hubs link with the mental health single point of access. The Senate recognises that this need for integration and seamless working with mental health has been emphasised by commissioners.

- 4.22 This section also states that specialist staff will be available in sufficient numbers to support patient care but it is difficult to quantify this without detail on what numbers are required and how this relates to staff employed in the system currently. Specialist staff are not easy to recruit.
- 4.23 **Page 20;** Details the meetings which the provider will wish to incorporate within their operational structure. This does not fit with the principle on page 4 of commissioners not being prescriptive in terms of the service model/ delivery teams/ staffing etc. This is just an observation from the Senate of a slight inconsistency in the approach.
- 4.24 **Page 29 onwards;** In the development of the KPIs it may be helpful to demonstrate to the provider how the CCG will make use of this information in a timely way that means that variances are spotted early and addressed and that there is a process for recognising external factors affecting the KPIs which are beyond the providers' control.

North Kirklees – Key Functions Document Comments

- 4.25 **Page 1**
- In the description of the hub it will be important to ensure consistency of decision making for the referrers e.g. in a nurse only team having the senior nurse on duty at any one time being the coordinator, or in an MDT setting ensuring there are standards and protocols in place
 - Care co-ordination, well-being and navigation. Commissioners may wish to consider if this is provided by the single point of contact or via the team or service referred on to
 - Commissioners may want to explore how the care navigators are tied into the over 75s named clinician and any other case managers
- 4.26 **Page 2 Care Homes;** A Senate review member informed the Senate of the Care Home Initiative in practice at Gateshead. The model is for each care home to have a link practice and each practice to have a lead GP who works with a nurse specialist for older people. This model has resulted in sustaining a reduction in avoidable admissions and readmissions and reduced length of stay for those patients that do need to be admitted. Essentially, it is through shifting from a reactive to a proactive model of care via comprehensive assessment and shared care planning.
- 4.27 **Page 4 Nursing;** Gateshead are also piloting a Frailty Practice Nurse which has to date, resulted in reduced A&E attendance, hospital admission and GP home visits through case management of 100 patients, when comparing their use of unscheduled care in the preceding year. More widely in terms of practice nursing, the Willis Report of 2012 identified that 45% practice nurses will be retiring by 2022

and commissioners may want to consider further developing the career framework for practice nurses to help alleviate this issue.

- 4.28 **Page 7 specialist nursing (adult);** It is not clear who these nurses are and what specialties they are from and if the specialist skills to reduce the need for admission is specialist, as in disease specific, or advanced practice rapid response generalists. The statement that this access will be achieved within a time limited response e.g. 2 hours if needed, needs consideration as specialist nursing numbers are generally low.
- 4.29 **Page 8 Rehabilitation;** Feedback from the National Audit of Intermediate Care in 2013 highlighted that given the complexity of needs of those most vulnerable and frail, it is becoming challenging to determine who needs recuperation, who needs rehabilitation and who needs re-ablement. Commissioners may want to consider an approach seeking to determine this after referral.
- 4.30 **Page 9 and 10 Occupational Therapy and Physiotherapy;** The Senate was unclear if this service is for rehabilitation and thereby part of an MDT or cluster team or whether this referring to complex adaptations and housing issues.
- 4.31 **Page 19 Medicines Optimisation;** Commissioners may want to further consider the pathways for the community administration of IV drugs and the importance of pharmacists and microbiologists being included.
- 4.32 **Page 22 Care Co-ordinator;** Commissioners may wish to explore how this role links with the over 75s accountable clinician.
- 4.33 **Page 28 Community based respiratory approach;** Commissioners may wish to explore how this ties into the specialist nursing approach and the case management.
- 4.34 **Page 30 Falls;** The review group queries whether it is possible to get standard assessment tools across all providers and whether there are places in patient pathways that can routinely assess for falls risks e.g. over 75 assessments or chronic disease management clinics in primary care.

5. Summary and Conclusions

- 5.1 The CCGs have developed specifications which are based on sound values and principles for delivering care closer to home. The Senate commends the CCGs on their vision for the future of their community services and acknowledges the complexity of the discussions during the last 2 years. The scope of services is comprehensive with little that could be considered a missed opportunity.
- 5.2 The Senate did find it very challenging to assess the risks due to the visionary style of the documents. We acknowledge that the detail will be worked through in the competitive dialogue process and therefore at this stage the presentation of the specification will leave gaps in the Senate understanding of the proposals. This has compromised our ability to assess if the risks have been addressed. Questions are raised within this report and we hope they will assist the commissioner in developing the service model in partnership with the provider during the procurement process.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

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

Dr Andrew Phillips, Urgent Care Lead, Vale of York CCG

Assembly Members

Peter Allen, Public Representative

Stephen Elsmere, Public Representative

David Broomhead, Therapy Consultant, Rehabilitation, Scunthorpe General Hospital

Dr Deepti Alla, General Practitioner, Princess Medical Centre

Simon Plummer, Physiotherapist, Fieldhead Hospital

Carol Weir, Clinical Lead, Children & Family Services, Leeds Community Healthcare Trust

Co-opted Members

Anne-Marie Seymour, Consultant in Palliative Medicine, Mid Yorkshire Hospitals NHS Foundation Trust

Dr Jon Scott, Consultant in Elderly Care, South Tyneside District General Hospital

Dr Nikhil Majmudar, Consultant in Elderly Care, Sunderland City Hospitals

Lesley Bainbridge, Strategic Lead, Older People's Services and Integrated Care, Gateshead Health 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
Steve Ollerton	CCG Chair	Greater Huddersfield CCG	12.8.14 & 20.11.14	Chair of the CCG that will be seeking advice from the Senate	20.11.14	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

CLINICAL REVIEW

TERMS OF

REFERENCE

**Calderdale, North Kirklees and Greater Huddersfield Strategic
Services Review**

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

Carol Mckenna

on behalf of Greater Huddersfield CCG

Chris Dowse

on behalf of North Kirklees CCG

Date:

Clinical review team members

Andrew Philips and Cathy Wright as leads from the Council. A working group comprised of representatives from:

- Community Services
- Primary Care
- Palliative Care
- Care of the Elderly
- Social Care
- Community Paediatrics
- Patient/ Citizen representatives

Aims and Objectives of the Clinical Review

For the Yorkshire and the Humber Clinical Senate:

- To consider if the following list of risks are recognised in the proposals and the extent to which the proposals within the specification will mitigate the risks.
- To appraise the proposed scope of services and consider if there are any missed opportunities.

Risk Id	Principal Risk
HSPB 2	There is a risk that there will be some deterioration in quality of service from the hospital due to the Trust not being able to address the workforce and service configuration issues, resulting in current workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate.
HSPB 13	There is a risk that the whole systems approach is compromised due to insufficient capacity and capability to complete and deliver the Primary Care Strategy resulting in a disconnect between primary care medical services and the vision and outcomes for the programme.
HSPB 15 CC2H r5	There is a risk of lack of clinical workforce and skills to deliver the services due to inadequate resource, resulting in delays and/or issues with implementation of the programme
CC2H 16	There is a risk that lack of information sharing will delay plans resulting in the community changes not being implemented
CC2H 27 CC2H r4	There is a risk that we do not deliver coordinated change across hospital and community services at sufficient pace and scale to address the significant quality, finance and workforce issues in our case for change, resulting in poor services being established/maintained
CC2H r16	There is risk that the agreed outcomes in the overarching specification are not achieved which would result in the original vision for care closer to home and the identified benefits for patients across the local health and social care system not being realised
CC2H r17	There is a risk that a seamless service for patients will not be realised as a result of this work due to the number of organisations / providers involved in delivering services locally which could result in the vision and outcomes for care closer to home not being realised

Scope of the Review

The first stage will consider community Services for Calderdale, Greater Huddersfield and North Kirklees CCGs. The second stage will consider hospital services at Calderdale and Huddersfield NHS Trust.

Timeline – Stage 1

Stages of early discussion	4 th July - November 2014
Establishment of clinical review team	December 2014
Information gathering	Community service specifications received 3 rd week in November Clinical Review Team and commissioning leads to arrange early January teleconference to discuss queries
Meeting with provider clinical representatives	queries to be dealt with by email and teleconference
Site visit (possibly combined with above)	not required
Consideration of evidence	December 2014 – mid January 2015
Report writing	mid - end January 2015
Reporting to council	20 th January 2015
Commissioner feedback	end January 2015
Report publication	to be agreed with commissioner as the review progresses

Reporting Arrangements

The clinical review team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will submit the report to the sponsoring organisation and this clinical advice will be considered by the commissioning sponsor. For work undertaken in the assurance role the clinical advice will also be considered as part of the NHS England assurance process for service change proposals.

Methodology

The review will be undertaken by appointing a clinical review team comprised of Senate Council members and co-opted members. The review will consider the following key evidence:

- North Kirklees CCG Service Specification, Schedule 2 (D4 NKCCG Outline Spec)
- North Kirklees CCG Functions Document V1(D4a)
- North Kirklees CCG Scope of Services V10 (D4b)
- Calderdale CCG Calderdale Closer to Home, Schedule 2, V3 and appendices
- Greater Huddersfield CCG, V0.3, Care Closer to Home Services
- Greater Huddersfield CCG and North Kirklees CCG Overarching Outline Service Specification and Supplementary information. September 2014 V1 and appendices.

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

The clinical review team will submit and agree their comments and the writing of the report will be co-ordinated by the Senate Manager. The clinical review team will agree the draft report.

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. Council meetings are scheduled for 20th January 2015 and 25th March 2015.

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.

A communications plan will be agreed with the commissioning sponsor.

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.

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.

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

BACKGROUND INFORMATION

- North Kirklees CCG Service Specification, Schedule 2
- North Kirklees CCG Functions Document V1
- North Kirklees CCG Scope of Services V10
- Calderdale CCG Calderdale Closer to Home, Schedule 2, V3 and appendices
- Greater Huddersfield CCG, V0.3, Care Closer to Home Services
- Greater Huddersfield CCG and North Kirklees CCG Overarching Outline Service Specification and Supplementary information. September 2014 V1 and appendices
- Calderdale CCG A2 Community Specifications (received 23rd January)
- Calderdale CCG and Greater Huddersfield CCG Community Services List (received 23rd January)