NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review

for

Multi-speciality Community Provider Service Specification on behalf of Scarborough and Ryedale CCG

Final Version 1.0

September 2017

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Yorkshire and the Humber Clinical Senate
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Version Control

Document Version	Date	Comments	Drafted by
Draft Version 0.1	August 2017	Initial draft report incorporating Working Group comments	J Poole
Draft Version 0.2	September 2017	Revised following commissioner teleconference	J Poole
Draft Version 0.3	September 2017	Revised following Working Group comments	J Poole
Draft Version 0.4	September 2017	Revised following commissioner feedback and Council comment	J Poole
Final Version 1.0	September 2017	Agreed final wording	J Poole

1. Chair's Foreword

1.1 The Yorkshire and the Humber Clinical Senate thanks Scarborough & Ryedale Clinical Commissioning Group (CCG) for the invitation to work with them on their outline service model and outline specification for integrated prevention, community care and support services for adults. I would like to thank the expert clinicians who have worked with us on this review.

1.2 We recognise the amount of work already undertaken by the CCG before our involvement and it is always difficult to be brought into a piece of work at such a late stage particularly when the much of the detail is developed within the competitive dialogue process. We have focused our attention on areas where we advise that the specification could be strengthened to minimise the clinical risk in the service model.

2. Summary of Key Recommendations

2.1 The documents are well written and thoughtful about the issues with a clearly presented rationale for the need for an alternative to current service provision. The focus on closer to home delivery clearly responds to the consultation with the public and the Senate is fully supportive of the aims and vision of the model.

2.2 The Senate recommendations are listed below:

- To more clearly set out the background information on the current services including any audit and assessment of these.

- To provide greater emphasis within the specification on the importance of the interdependent services.

- To more clearly articulate the frailty model within the specification and to make the role of the community geriatrician, the GP and the wider MDT clearer within that.

- To include within the specification or dialogue process example cases for commissioners to assess how effectively the proposed model responds to the given scenarios.

- To include additional detail within the specification on the elderly medicine service.

- To more clearly acknowledge the workforce issues and how the bidder will need to address those.

- To strengthen the service specification in relation to mental health, delirium and dementia services and the services provided to those patients who are suffering from alcohol or substance misuse

- To consider the implications for the Vale of York CCG practice populations in Ryedale and address this issue through discussion with the Vale of York CCG and the Local Authority and to reflect on whether the specification needs to include further information on the diverse geography

3. Background

Clinical Area

3.1 Scarborough and Ryedale CCG have identified the need to improve their population's access to community health and social care and respond to the priorities identified in the Sustainability and Transformation Plan (STP) for Humber Coast and Vale. The CCG has therefore worked with its partner organisations to develop a model for an integrated prevention, community care and support service for adults. The aim is to deliver care at or as close to home as possible and to organise services around the communities where people live and the GP practices people use. The CCG wish to put prevention and self-care at the heart of the model.

3.2 This overall vision for fully integrated care includes a full range of services which the CCG and North Yorkshire County Council will jointly plan and commission over a period of time. As part of that ambition the CCG is procuring a provider to deliver a new model of care – a partial Multispecialty Community Provider (MCP). The detail of this model is included within the MCP prospectus and supporting documentation provided to the Senate. It is acknowledged however that much of the detail of the service model will be developed with the bidders during the procurement.

Role of the Senate

3.3 As part of the assurance process with NHS England the CCG asked the Senate to provide an independent clinical review of the appropriateness of the outline service model and outline specification for the locality and populations of Scarborough & Ryedale. The CCG wish to incorporate the Senate comments about the outline specification in their conversation with bidders for their inclusion within the proposed service model.

3.4 In considering this documentation, the specific question the Senate has been asked to address is:

Can the Clinical Senate review the SRCCG outline service model and the outcome based service specification to provide input and suggestions as to where and how the model can be more clearly defined and the service specification should be more explicit, so that clinical risk can be minimised.

Process of the Review

3.5 The Terms of Reference were agreed on 24th July 2017 and are available at Appendix 3. The supporting documentation was received by the Senate on the 18th July and distributed to the Expert Working Group on 21st July. The Senate working group shared comments on the documents by email and supplemented this with a clinical discussion by teleconference on 23rd August. Initial questions were sent by email to the commissioners and followed up with a teleconference between the panel and the commissioners on 6th September. The commissioner responses were taken

into account within the further panel discussion. Once consensus was reached on the draft report it was sent to the commissioner for comment on 11th September to enable the commentary to be included within the revised specification.

3.6 Commissioners are given 10 working days to respond with any comments on the accuracy of the report. The report is to be discussed by the Senate Council on the 18th September.

4. Evidence Base

4.1 The documentation sets out the national strategic context and the local priorities outlined within the Sustainability and Transformation Plan particularly within Section 1.2 of the MCP Prospectus and the Senate agrees that the service model proposals are in alignment.

4.2 The underlying evidence base regarding the effectiveness of primary, community and intermediate care is still only emerging. Due to the lack of specific clinical guidance, the clinicians involved in this review worked to achieve a consensus based on experience and judgement.

5. Recommendations

Overview

5.1 The documents are well written and thoughtful about the issues with a clearly presented rationale for the need for an alternative to current service provision. The focus on closer to home delivery clearly responds to the consultation with the public and the Senate is fully supportive of the aims and vision of the model.

5.2 The Senate comments are intended to assist commissioners in strengthening and more clearly defining the service specification which will support the dialogue process. It is recognised that any plan spanning 2 years will need to be allowed to evolve in response to the environment and other planned services.

The Current Position

5.3 Senate panel members commented that it would be helpful to have more detail on the current acute and community models of care to understand where the pinch points are in the system and where there are any quality and performance issues. The documents state that the current lack of integration is leading to patients being cared for in secondary care as the safe default but more information on this would be helpful for bidders in designing a service model that can overcome these issues.

5.4 Commissioners are aware that their lack of data to understand baseline demand and activity and to evaluate the effectiveness of the current community contract will make it more difficult to assess whether bidder proposals will bring about a more effective

way of working. Through discussion the Senate understands that one of the issues the CCG wish to address in the new contract is the inclusion of Key Performance Indicators (KPIs), quality standards and data collection. The Senate supports the need for a much greater focus on these within the new contract.

Recommendation: *To more clearly set out the background information on the current services including any audit and assessment of these.*

Organisational Engagement and Boundaries

5.5 In developing the ethos of one organisation in the new model, a major issue will be developing the trust between the collaborating organisations. The interdependent organisations are listed but the importance of securing good relationships between the MCP and these services to ensure the success of the model cannot be underestimated. The documents refer to higher than national average levels of people in deprivation and poverty, smoking and alcohol related health conditions. The need to therefore work closely with the voluntary sector on preventative approaches in these specific communities will be a priority. Engagement with Yorkshire Ambulance Service (YAS) is also essential as they are likely to be central to any rapid response processes. Furthermore, as the phase 1 element is not fully 24/7, other providers will need to understand how they will work with the service and this will need careful management.

5.6 The CCG have confirmed the expectation for the bidders to build relationships with all these interrelated services which will be tested as the procurement develops. The Senate advises of the need to focus on this within the evaluation. Within our panel, our patient representative questioned whether the integration would result in a named key worker assigned to an individual who can work with the patient holistically to really integrate their access to services.

Recommendation*: to provide greater emphasis within the specification on the importance of the interdependent services.*

5.7 The Senate felt that there was a lack of detail on the relationship with the local authority but understand from discussion with the commissioners that a Section 75 joint commissioning agreement with North Yorkshire County Council (NYCC) has been set up and it is planned that budgets will be pooled over time. We understand that there will be an integration agreement between NYCC and the ultimate provider that will set out the commitment to integration.

5.8 Two specific points raised by the panel were how will speech and language therapies be provided and whether the hospice at home service should be included within the scope of this procurement particularly if it extends to people in their last 3 months of life. The Senate also questioned whether this work will align with the development of advance care plans (ACP) for people in their last year of life.

The Role of the GP and the Frailty Service

5.9 The Senate agreed that it would be useful to know more at this stage about engagement with all the practices and how the input from Primary Care is going to be

sufficiently costed, supported and evaluated. It would have been helpful to understand the demographics of GP practices, their sustainability, how many need to merge and what model there is for them working together.

5.10 The documentation states that it will put General Practice at the heart of the delivery of the model and many of the Senate panel members concerns related to their role and their ability to fulfill the functions within the frailty service. Through discussion with commissioners we understand that the GP community has been involved in the process towards procurement for some time and have helped to shape the model. The CCG have confirmed that they are using two non-conflicted GPs from other CCGs to ensure that the GP perspective is there throughout the process. The CCG have stated that it is expected that GPs will be central to delivery because the new service model is wrapped around groups of practices with integration agreements ensuring that the services are developed in partnership. Over time the CCG hope that the new model will take some pressure of GP practices and provide them with more options for caring for people at home. .In discussion, commissioners discussed how they saw the frailty service developing to include the community geriatrician.

5.11 The Senate advise that the frailty model commissioners articulated in discussion doesn't come through within the specification. It is evident that the frailty service will be a key part of the package of services and integral to the success of the model yet the documentation does not describe the Frailty Team other than it will be primary care led. This led to the Senate panel questioning what this service will look like, what community geriatrician input there will be into this team and the role of the wider Multidisciplinary Team (MDT) and whether practices are currently identifying their frail populations. The frailty model for the GPs is based on more capacity to screen and assess frail patients but the starting point and the aims of percentage increase are not made clear. Our advice is to include more detail at this stage in the specification rather than this being developed only in dialogue as there is a good opportunity to build this service and prevent unnecessary admissions. The Senate panel also questioned whether the objectives of the service should be widened to include prevention and proactive management.

5.12 It was also noted that there are a high proportion of acute admissions for gastroenterology which is unexpected given the demographics. For most areas falls, respiratory conditions and urinary tract infections are amongst the leading causes for admission. UTIs are often a marker for frailty and vulnerability rather than a GU condition in their own right and can relate to continence and carer stress in relation to dementia, for example.

Recommendation: *to more clearly articulate the frailty model within the specification and to make the role of the community geriatrician, the GP and the wider MDT clearer within that*

5.13 To help to flesh out the detail of the frailty service and the wider model with the bidders it would be helpful to provide them a range of typical scenarios which lead to admission or GP involvement and work through how each provider would react to that scenario to provide an alternative high quality service to that patient.

Recommendation: *that the specification or dialogue process includes example cases for commissioners to assess how effectively the proposed model responds to the given scenarios*

Elderly Medicine

5.14 The Senate questioned whether there is opportunity to combine the community elderly medicine service with the frail elderly service as there will be significant overlap between these. Most of the objectives of the community elderly medicine service description are congruent with the frailty service and combining them would be another move away from fragmented services.

5.15 The improvements to elderly medicine are planned to start in phase 2 which is far into the other service reconfigurations. The Senate clearly understands the need to adopt a phased approach to the services given the challenges of this procurement. We understand that the assessment with the bidders will consider the support that there will be given to services up to and during transition. The elderly medical cover is one example of this. The Senate questioned whether there are plans for an Ambulatory Service accessible to GPs to get quick workups done on patients without the need to admit or whether telephone or e-mail advice for GPs will be available from a Duty Geriatrician or consultant nurse/ therapist.

5.16 We also felt that it would be helpful to provide more detail on the arrangement of the sort of new patients seen by the consultant geriatrician and followed up by specialist nurses and the geriatricians input into a clinical discussion outside of the 9 – 5 service. Without the out of hours support we felt there was an opportunity lost in avoiding unnecessary admissions.

Recommendation: *to include additional detail within the specification on the elderly medicine service*

Recruitment and Retention and the Wider Workforce

5.17 The Senate acknowledges that much work has been done to address the recruitment and retention issues of GPs and the wider workforce and are grateful to the CCG for the helpful discussion outlining their initiatives with the Local Medical Colleges (LMC), Health Education England (HEE) and other organisations. The Senate advises that it may be helpful to articulate this more fully with the bidders within the documentation both in relation to GPs and the wider workforce. Although we recognise that the specification may not be the appropriate place to discuss the range of recruitment and retention initiatives it does need to highlight how the bidder will need innovative approaches to attract people to the area, especially in the face of growing shortages of qualified staff coming through training.

5.18 Currently within the specification there is little information on the proposed workforce structures and skill mix. The commissioners have confirmed that they expect bidders

to come back with their workforce models that will be discussed through dialogue and evaluated as part of their final tenders. The Senate remains of the opinion that the specification would be strengthened through greater detail on recommended workforce, skill mix and career pathways.

***Recommendation**: to more clearly acknowledge the workforce issues and how the bidder will need to address these.*

5.19 If the proposal is to transfer staff from the acute sector for this model the Senate questioned the provisions that have been made to protect acute services and ensure continuity of care in this sector. The Senate also questioned what clinical leadership will be put in place to help with the cultural change need for this MCP model.

Mental Health and Dementia Services

5.20 There is very little mention of mental health apart from the need to ensure links with secondary care services such as mental health. The Senate questioned the provision that is being put in place to accommodate the specific needs of people with mental health issues using community services to help them to engage in their care. Similarly there is little mention about dementia care within a growing elderly and frail population. In response the CCG advised that they have a comprehensive community mental health service from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) which is jointly commissioned with two other CCGs and the contract is not due to expire for several years. TEWV have been engaged in the MCP plans and are happy to be a key partner and support the model. The expectation is that each of the bidders will be talking to TEWV and this relationship will be tested out with bidders to see how they will secure the mental health partnership and all of the other necessary partnerships to make sure care is as integrated as possible for services not directly in the MCPs control.

5.21 The Senate acknowledges this response and advises that mental health services need a greater profile within the specification to ensure this becomes an integrated part of the service provision. All of these planned services need accessible and timely access to mental health services for advice and support and there will be opportunity to improve on current arrangements. Within the cohort of frail elderly patients with a history of falls for example there will inevitably be a large number of people with dementia, cognitive impairment and delirium. Our advice is that the lack of mention of delirium, mental health, depression, dementia and social isolation, which are all central to tacking admissions avoidance, is a gap within the current specification. The Senate also questioned why dementia diagnosis rates are significantly lower than the national ambition and what opportunities there are to improve this.

Recommendation: to strengthen the service specification in relation to mental health, delirium and dementia services and the services provided to those patients who are suffering from alcohol or substance misuse

The Geography

5.22 The geography of the CCG is challenging with wide variation from deprived urban areas to sparsely populated rural areas. It wasn't clear from the documentation how the model will accommodate those differences as a one size model will not fit this diverse region. The public engagement document shows wide consultation and the CCG may wish to consider some breakdown into the issues being raised by the public in the different GP clusters to inform the bidder on how the model will need to adapt to the differing population needs. The CCG consideration of how the model needs to accommodate the summer peaks in population is also not reflected in the specification.

5.23 It is noted that although the CCG is called Scarborough and Ryedale there are three practices that are in Ryedale but are part of the Vale of York CCG. The community services for this area would be split by this proposal leaving a rump community service for those three practices of about a 20,000 population. Furthermore Malton Hospital sits in the far west of Scarborough and Ryedale CCG just south of the 3 practices. A model which excluded use of the service through non-inclusion of these practice populations in the MCP would seem to threaten the sustainability of this hospital longer term. We advise the CCG to consider the implications for the Vale of York CCG practice populations in Ryedale and address this issue through discussion with the Vale of York CCG and the Local Authority.

Recommendation: *To consider the implications for the Vale of York CCG practice populations in Ryedale and address this issue through discussion with the Vale of York CCG and the Local Authority and to reflect on whether the specification needs to include further information on the diverse geography.*

5.24 The Senate panel also wish to highlight a number of other areas where commissioners may wish to amend the specification to include further detail. These are not included as recommendations as we understand that these areas are being addressed within the dialogue process but we leave them in the report for commissioner consideration**.**

5.25 **Outcomes.** There are no apparent levels of achievement set against some of the KPIs. Some broad level of outcome achievement is required to enable the assessment of the service and to evaluate whether the strategic aims in relation to quality and outcomes are being met. Commissioners have acknowledged this gap which is due to the lack of baseline information within the current contract. It is the intention of commissioners to firm up these KPIs within the first few months of working with the new provider and the Senate agrees with the need to make this a priority.

5.26 **Out of Hours Service.** There is a clear aim for an integrated 24/7 service but the documentation does not detail the out of hours services which is when the majority of inappropriate admissions occur. The primary care service is described as being led by GPs, however, this only appears to apply in-hours. The Senate questioned what happens with extended access under GP Forward View (GPFV) and how do GPs integrate with the proposed clinical advisory service within NHS111 which will have

direct booking access to GPs and community services. Some of the services, such as the Primary Care Frailty Team, are not available evenings/overnight and it is not clear how the new MCP will ensure that patients accessing healthcare overnight are not admitted.

5.27 **Community Beds.** The documentation details how access to the community beds is currently inequitable and needs to be addressed to allow patients to access beds locally. The Senate questioned whether these beds are "step up" as well as "step down" and how the step up beds will be paid for if the plan is to use these. It was felt that patients and their carers will find it difficult to accept admission to a community bed in a care home short term whilst being further assessed if they will have to pay for this, if the alternative, albeit perhaps inappropriate, is a bed that is free to the patient in the acute hospital.

5.28 A specific point raised was that there will be direct competition for these community beds with patients in Ryedale under Vale of York CCG and what the arrangements will be around this issue.

5.29 **Care Homes.** The Senate is not clear how the care home provision fits within the MCP. One of the unclarified issues is the number of people being admitted to hospital from care homes in the locality including the reasons for this. This may be due to the lack of skilled care home staff which is driving some of the admissions. The CCG may wish to address how they will increase the care placements with skilled staff and increase more skilled home care staff to support the significant number of people living alone in the locality.

5.30 **Technology.** There is a lack of detail in the documentation about the technical support to allow seamless communications between Primary and Secondary Care and the various community teams which are all working on different IT systems. Commissioners acknowledge that the sharing of patient information on the same platform across health and social care is a key challenge to the success of this MCP and there is extensive discussion on this within the dialogue process.

5.31 **Engagement.** The CCG have been very honest and open with their feedback from the public and this is to be applauded. It is difficult to reach a high level of public engagement and this example is no exception. The Senate questioned whether the CCG intend to share the findings and the current proposals with the public and what implications this would have for the proposed timescale.

6. Summary and Conclusions

6.1 The documents are well written and thoughtful about the issues with a clearly presented rationale for the need for an alternative to current service provision. The focus on closer to home delivery clearly responds to the consultation with the public and the Senate is fully supportive of the aims and vision of the model.

6.2 The Senate advises that there is opportunity to further strengthen the service specification which will benefit the dialogue process with bidders and result in an improved service model. Our recommendations include the need to be clearer on the current service and its issues and the importance of developing the relationships with the interdependent services. The workforce and the geography are also key factors which we advise could be strengthened within the report.

6.3 Within the service model detail we recommend more information on the frailty service and the elderly medicine service and advise that there would be benefit to be gained in working through example cases with the bidders to test out their service model and its ability to avoid the unnecessary admissions. Mental health and dementia services also need a much greater priority within the specification.

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, Joint Medical Director, Vale of York CCG

Assembly Members

Sue Cash, Citizen Representative

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, South Yorkshire and Bassetlaw and North Derbyshire Cancer Alliance GP clinical lead

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Name	Job Title	Organisation	Date of Declaration	Reason for Declaration	Proposed way of Managing Conflict
Andrew Phillips	Joint Medical Director. Clinical Lead for Unplanned Care and Clinical Lead for Out of Hospital Care,	Vale of York CCG	25.7.17	Knows their Clinical Leads and often work within their OOH service which would link into the service being commented upon. Responsibility for services neighbouring Scarborough and Ryedale	This conflict is limited to: * his CCG being geographically adjacent to the CCG whose services are under review with the potential for some patient cross border movement between services. * working with the OOH service which will link with the service being commented upon. Andrew has no financial interest in the service and it has been agreed that Andrew can participate in this review with the conflict of interest noted. Andrew will abide by the confidentiality agreement and not disclose any information to parties outside of the Working Group.
Tolulope Olusoga	Consultant Psychiatrist for Older Adults and Senior Clinical Director (MHSOP-Trustwide) And Clinical Advisor - Dementia Diagnosis and Treatment Services Yorkshire and Humber Clinical Network	Tees, Esk and Wear Valleys NHS Foundation Trust	25.7.17	Tees, Esk and Wear Valleys NHS Foundation Trust falls within the list of partners and stakeholders with whom bidders will need to engage	Dr Olusoga has no financial interest in the service and Dr Olusoga is not in a position to provide his Trust with any unfair advantage through being part of this review panel. It has been agreed that Dr Olusoga can participate in this review with the conflict of interest noted. Dr Olusoga will abide by the confidentiality agreement and not disclose any information to parties outside of the Working Group.

Appendix 3

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Review of the MCP Service Specification on behalf of Scarborough and Ryedale CCG

Sponsoring Organisation: Scarborough and Ryedale CCG

Terms of reference agreed by: Carrie Wollerton, Executive Nurse, Scarborough and Ryedale Clinical Commissioning Group and Joanne Poole, Yorkshire and the Humber Senate Manager

Date: 24th July 2017

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1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Catherine Wright, Allied Health Professionals Lead, Bradford District Care Trust

Citizen Representative: Sue Cash

Clinical Senate Review Team Members:

Dr Andrew Phillips, Joint Medical Director, Vale of York CCG

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

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Can the Clinical Senate review the SRCCG outline service model and the outcome based service specification to provide input and suggestions as to where and how the model can be more clearly defined and the service specification should be more explicit, so that clinical risk can be minimised.

Objectives of the clinical review (from the information provided by the commissioning sponsor): To provide an independent clinical review of the outline service model and outline specification for integrated prevention, community care and support services for adults. The Senate review is part of the assurance process.

Scope of the review: The Clinical Senate to provide their view, based on the documents provided, as to the appropriateness of the outline model for the locality and populations of Scarborough & Ryedale.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: NA

Agree the Terms of Reference: by end July 2017

Receive the evidence and distribute to review team: evidence received 18th July. Clinical panel to be appointed by end July

Teleconferences: 23rd August for Working Group discussion. Commissioner comments/corrections on the draft report to be received via email

Draft report submitted to commissioners: by 4th September

Commissioner Comments Received: within 10 working days of receipt

Senate Council ratification 18th September

Final report agreed: end of September

Publication of the report on the website: The report cannot be published until after contracts have been signed with a preferred bidder, because of the confidential nature of the procurement and the possibility of procurement challenge.

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:

- MCP Prospectus
- Engagement and Equality Impact Assessment Report
- Outline of Service Requirements
- Background Information Document

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 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:

- Scarborough and Ryedale Clinical Commissioning Group, Outline of Service Requirements, MCP for Integrated prevention, community care and support services (adults)

- Scarborough and Ryedale Clinical Commissioning Group, Plan for the development of a new care model: Integrated Prevention, Community Care and Support Services (adults), Engagement and Equality Impact Assessment Report (finalised), 20th April 2017

- Scarborough and Ryedale Clinical Commissioning Group, Integrated Prevention, Community Care and Support Service, Background Information Document

- Scarborough and Ryedale Clinical Commissioning Group, Integrated Prevention, Community Care and Support Service, MCP Prospectus

- Scarborough and Ryedale Clinical Commissioning Group, Integrated prevention, community care and support service (adults)Draft KPI schedule

- Scarborough and Ryedale Clinical Commissioning Group, Integrated prevention, community care and support service (adults) Outcomes and Key Performance Indicators