Thames Valley Clinical Senate

Oxfordshire Transformation Proposal

Clinical Assurance Review

Version Control

Version	Date	Description	Author	Status
V0.1	15.09.16	First draft for comment	W McClure	With Senate Chair and Review Chair for comment
V0.2	14.09.16	Draft incorporating comments from Senate Chair and Review Chair	W McClure	With review team members for comment
V0.3	19.09.16	Draft incorporating comments from Clinical Review Team	W McClure	Agreed by review team Forwarded to Oxfordshire Team
V0.4	8.11.16	Draft updated to include outcome of final review on 7.11.16	W McClure	
V0.5	8.11.16	Draft updated by Phil Yates	P Yates	
V0.6	9.11.16	Updated draft to include comments	W McClure	
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V0.10	24.11.16	Updated following OCCG accuracy check	W McClure	Sent to TV Clinical Senate Council Members
V0.11	30.11.16	Updated following Senate Council meeting on 29.11.16	W McClure	Final version.

Contents

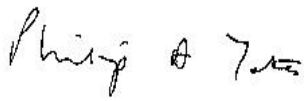
Foreword by: Clinical Review Team Chair, Dr Phil Yates

The NHS is well aware that its services, planning and payment mechanisms are not as integrated and seamless as the patient requires them to be. The past decade or two have unwittingly introduced a range of policies which have undermined intra-organisational clinical relationships, encouraged payment primarily for activity whether or not that activity was ultimately in the best interests of the patient and led to an investment of precious tax-payer resource in parts of the system not best placed to maximise patient self-determination and independence.

It has come to the fore that this is far from optimal. Although it would be financially unsustainable given the changes to demand and workforce to continue this trajectory, it is fundamentally the belated recognition that this is not producing the best service for patients that is now driving change. Patients want accessible excellent care – an integrated, seamless delivery of good service using all the 21st century technological capability that now permeates much of our lives in other sectors making it easy to deal with routine matters. They want local provision of care where feasible but when specialist intervention is required they want it in the best site for that care, where they are assured of appropriate expertise and good results.

Oxfordshire has recognised the need for change earlier than most. The current focus on Sustainability and Transformation Plans arising in early 2016 has been predated by them setting up a Transformation Board that has been at work over a much longer timeframe. The intention of the Board is to propose changes that are more than just service alterations but which should fundamentally re-examine the relationships between all providers and commissioners and move to a population-focused system where the greatest health gain is available to the highest percentage of the population. Such a system challenges all our preconceptions – about our personal responsibilities; the nature of presenting problems both physical and psychological; medical treatments; place of care and our need for particular estates; workforce skills, competencies and flexibility; and finally the financial flows that should follow the answers to the preceding issues.

This review of the plans of the Transformation Board by an independent Clinical Review Panel of external experts forms one component of the processes that must assure Oxfordshire's plans before they can be implemented. It assesses plans against the panel's judgement of patient safety, appropriateness and conformity with best practice – as evidenced by existing research and in light of the panel's senior clinical experience and assessment. Although the panel recognises there is more to be done for the Transformation Board to truly live up to its title, I trust this review and its findings add constructively to the reform of Oxfordshire's NHS services.



1. Senate Chair Summary and Recommendations – Dr Jane Barrett

Thames Valley Clinical Senate has been asked to review the system transformation proposals developed by Oxfordshire Clinical Commissioning Group (CCG) for its local population as part of NHS Englnd's assurance process. At a time of major financial restraint in the NHS coupled with increasing demand, it is clear that the way healthcare is delivered locally must change. Oxfordshire CCG has taken the brave step of attempting to define a new model of care.

This project has been an evolving picture and nobody should underestimate the complexity of the task that Oxfordshire CCG has set itself. Although the final brief is smaller than in the original plans, and this has an impact on the interdependencies, it is hoped that the views of the Senate will assist in future planning.

The main recommendations of the report are to be found in section 7 and it can be seen that a lot has been achieved but there is more work to be done to ensure that the plans are cohesive and detailed enough to enable provision of safe, sustainable and equitable care across the county.

I am very grateful to all the expert team who reviewed the proposals and who gave up their time to attend meetings at short notice. Under the expert chairmanship of Dr Phil Yates they have produced a report that Thames Valley Clinical Senate endorses and hopes will provide constructive advice as the plans evolve.

2. Background

The NHS is facing a number of challenges to the services it delivers: funding limits, population growth and more people living longer with complex health issues.

NHS England's Five Year Forward View sets out how the NHS needs to change to meet the requirements of the future and shows us what that future will look like. It describes a future that empowers patients to take much more control over their own care and treatment. A future that dissolves the classic divide between family doctors and hospitals, between physical and mental health, health and social care and prevention and treatment. It is a future that no longer sees expertise locked into often out-dated buildings, with services fragmented and patients having to visit multiple professionals for multiple appointments. The future will see services delivered on a place based model with far more care delivered locally but with some services in specialist centres where that clearly produces better results.

Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Local authorities now have a statutory responsibility for improving the health of their people, and councils can make an important impact.

In common with other health systems, Oxfordshire is facing challenges in continuing to provide health services for its growing population both now and into the future.

2.1 Geographical Background

Oxfordshire is the most rural county in the South East and has a population of circa 672,000. The population has grown by more than 10% in the last 15 years and it is expected to continue growing, due to increases in life expectancy and more people moving into the county. A third of the population, and proportionately more of those aged 65 and over, are living in towns or villages of less than 10,000 people

Oxford has a global reputation for its world class university and academia and its workforce is amongst the most highly qualified in England.

Oxfordshire's clinical leaders have been working together for a couple of years under a transformation umbrella to understand the future challenges facing the health services in their patch. They are developing options for public consultation which are focussed on ensuring that services will be safe and sustainable into the future.

2.2 Scope and Limitation of Review

The scope of this review is to provide assurance on the clinical aspects of the proposed options within the Oxfordshire Transformation Plan assessing the clinical quality, safety and accessibility of the proposals. The Oxfordshire Transformation Plan will be subject to a full

NHS England Stage 2 assurance process and the Senate clinical review will form a component of this.

The initial timescales supplied to the Senate, by the Oxfordshire Transformation Team, have been subject to change, as have the scope and scale of the services for review. This reflects the complexity and challenge of taking forward reconfiguration proposals and the level of work required to fully work through potential service change. The changes in timescale and scope have, in turn, created challenges for the Senate in carrying out this review and resulted in the loss of an overarching vision which made it difficult to adequately assess the consequences of decisions.

The initial review, carried out on 5th September 2016, was treated as an interim review as service changes were still being developed. The Clinical Review Team (CRT) response was reported to the Oxfordshire Team to support the ongoing development and the preparation for the final review which was scheduled for 7th November 2016. The output of Day 1 is recorded here for completeness.

As stated above, the proposals presented for review on 7th November 2016 were not the same as had been presented in September and additionally, separate questions for the clinical areas were asked of the CRT on Day 2.

The role of the CRT is to:

- Assess the strength of the clinical case for change
- Check alignment with clinical guidelines and best practice
- Ensure a full range of options have been considered and that potential risks are identified and mitigated
- Assess the alignment between the proposed change and strategic commissioning intentions
- Assess the clinical case for change for each of the proposed options in order to provide clinical assurance and sign off from the Thames Valley Clinical Senate

3. Methodology of the Review

The methodology of the review was informed by national guidance and the Clinical Senate Review Process: Guidance Notes (2014)

3.1 Terms of Reference

The aim of the CRT is to assess the clinical quality, safety and sustainability of the proposed model of care prior to public consultation in line with the agreed Terms of Reference (see Appendix 1)

3.2 Process

The draft documentation to support the clinical case for change for the initial assessment on 5th September 2016 was supplied to Thames Valley Clinical Senate week commencing 22nd August 2016 and was reviewed and assessed at an Independent CRT meeting on 5th September 2016.

The documentation was revised and re-presented to the Senate on 21st October 2016 in readiness for the Independent Clinical Review Team on 7th November 2016. This subsequent submission was reduced in size with the key elements of Community Hospitals and Primary Care being withdrawn for further development. On 4th November 2016, the Oxfordshire Transformation Team confirmed that the elements relating to Children's Services and to Emergency Departments would also be deferred to Phase 2.

The CRT included members from professional groups with specific knowledge and expertise in those areas on which the Clinical Senate had been asked to provide advice. To ensure that any advice given was robust, transparent and credible, the CRT included clinical expertise from outside the Thames Valley Area. – see Table 1. A confidentiality agreement was signed by all CRT members and any potential conflicts and associations were declared during the process. * denotes that a potential conflict of interest was declared which was noted by the Chair but did not exclude the member from discussions.

This report presents the key issues that were discussed and emergent themes from the evidence presented (both documentary and verbally). It is not intended to be a comprehensive record of the discussion. The CRT's main observations and conclusions are presented as per the Clinical Senate Review Process: Guidance Notes (June 2014).

Table 1

Name	Position	Organisation
Phil Yates	Chair	Chair of the South West Clinical Senate
Sian Butterworth	Paediatric consultant and paediatric lead for the Isle of Wight	
Peter Hockey *	Consultant Respiratory Physician and Clinical Director	Southern Health NHS Foundation Trust
	Deputy Postgraduate Dean	Health Education England (Wessex)
Jane Hogg	Integration and Transformation Director	Frimley Health NHS Foundation Trust
Lise Llewelyn	Strategic Director of Public Health	Berkshire
Ann Remmers	Clinical Director	South West Maternity and Children's Clinical Network
	Patient Safety Programme Director	West of England Academic Health Science Network
Jonathan Serjeant	Clinical Director	Here (previously Brighton and Hove Integrated Care)

Christine Teller	Public Contributor	Bristol
In attendance		
Wendy McClure	Senate Manager	Thames Valley Clinical Senate
Vida Addison	Senate Project Officer	Thames Valley Clinical Senate

4. Description of the Current Service Model

The current healthcare service model is the traditional one of primary care, acute providers, mental health providers and community providers. There is one Clinical Commissioning Group (CCG), Oxfordshire CCG, made up of 72 GP practices which are organised into 6 localities:

- **North** – 12 practices covering Banbury, Bloxham, Chipping Norton, Cropedy, Deddington and Sibford. It has a patient population of 109,322 (15%)
- **North East** – 7 practices covering Bicester, Kidlington and Yarnton, Woodstock and Islip. It has a patient population of 81,852 (11%)
- **Oxford City** – 22 practices covering Oxford City, Kenington and Botley. It has a patient population of 209,155 (29%)
- **South East** – 10 practices covering Wheatley, Sonning Common, Thame, Wallingford and Henley on Thames. It has a patient population of 92,200 (13%)
- **South West** – 12 practices covering Abingdon, Clifton Hampden, Berinsfield, Didcot, Wantage and Farringdon. It has a population of 144,133 (20%)
- **West** – 9 practices covering Witney, Carterton, Eynsham, Charlbury, Burford and Bampton. It covers a patient population of 81,194 (11%)

The Oxford University Hospitals NHS Foundation Trust OUHFT), is made up of four hospitals. The John Radcliffe Hospital (JR), one of the largest NHS teaching trusts in the UK, which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre and Women's Centre); the Churchill Hospital and the Nuffield Orthopaedic Centre all of which are located in Oxford. The fourth hospital is the Horton General Hospital in Banbury, north Oxfordshire which is a small District General Hospital (DGH) with 24 hours per day access to A&E, acute geriatric beds, obstetrics and 150 overnight beds across various specialities.

There are a further eight community hospitals which are operated by Oxford Health NHS Foundation Trust, the mental health and community provider. These range in scale from 8-50 beds. Some have advanced urgent care close to home while others are more traditional with bed based care for step down. The community hospitals are:

- Abingdon Community Hospital – 42 beds
- Bicester Community Hospital – 11 beds
- Didcot Community Hospital – 42 beds
- Oxford City Community Hospital (The Fullbrook) – 14 beds
- Townlands Hospital
- Wallingford Community Hospital – 27 beds (includes midwifery)

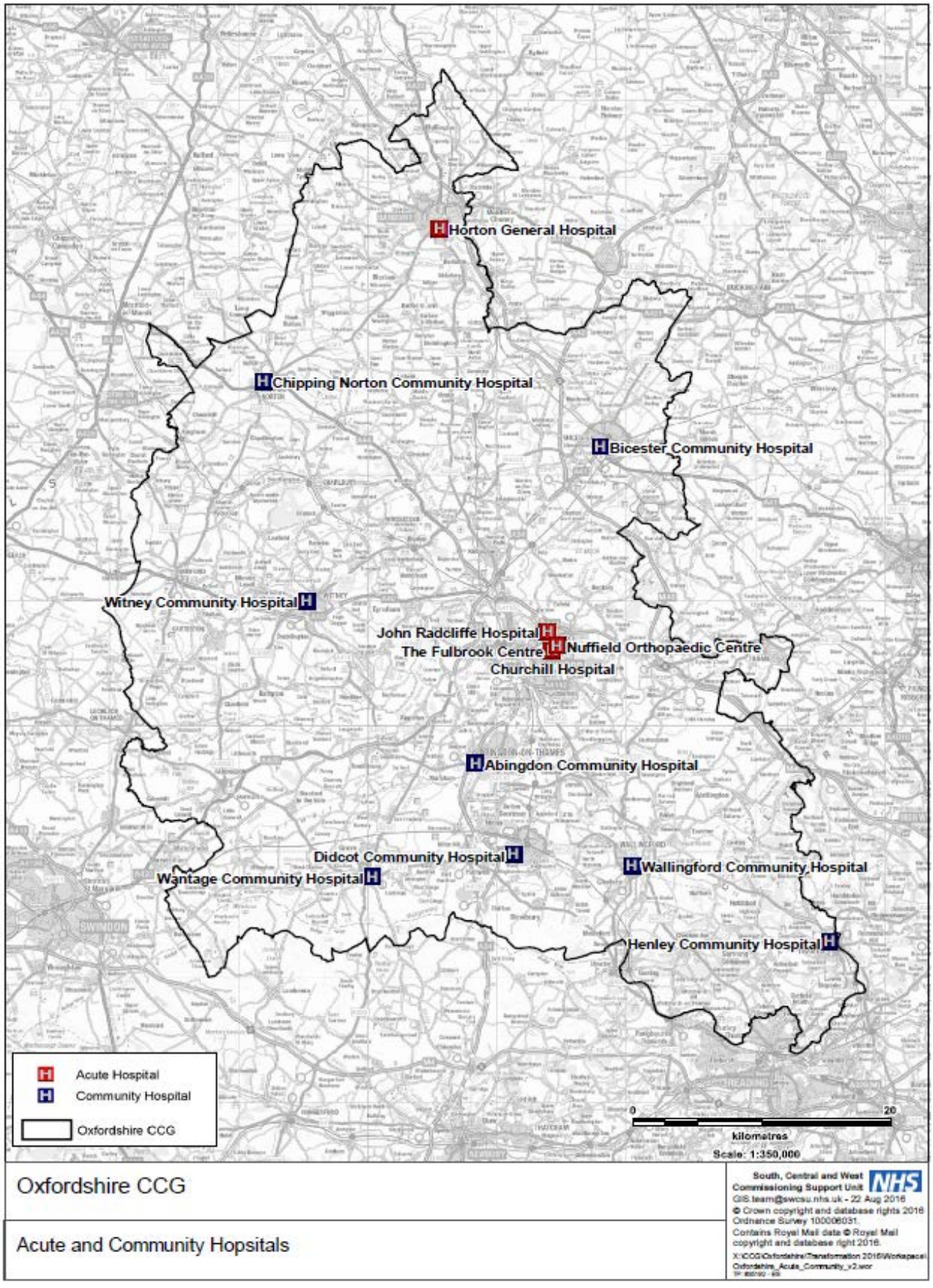
- Wantage Community Hospital – 14 beds (includes midwifery)
- Witney Community Hospital – 60 beds

In addition to these hospitals managed by Oxford Health, there is a community hospital at Chipping Norton. There are a range of services run by different providers which include Intermediate care beds run by Order of St John. There is also an NHS midwife led unit and a range of other community services.

The area is covered by the South Central Ambulance Service NHS Foundation Trust (SCAS).

Oxfordshire has one county council and five district councils.

Table 2: Map of Oxfordshire showing locations of acute and community hospitals.



5. The Case for Change

In its overview document to accompany the review documentation, Oxfordshire CCG states that the annual spend for health and social care services is about £1.2 billion today, and is anticipated to rise to £1.3 billion by 2020/21. If healthcare continues to be delivered as it is today, it is anticipated that by 2020/21 there will be a deficit of £134 million.

Alongside the financial challenge, the case for change states that Oxfordshire is facing workforce shortages across the healthcare system from challenges to replacing GPs as they retire and a high turnover of residential home and social care staff to difficulty in recruiting specialist acute doctors. In part this is attributed to the high cost of local living, and proximity to London where a 'weighting' premium is paid to NHS staff. Recruitment problems have already forced service changes within Oxfordshire, for example at the Horton General Hospital where the obstetric unit has been temporarily closed.

While the quality of health services provided in Oxfordshire is generally good, the Transformation Team has raised concerns over the future sustainability of safe and high-quality services.

In line with Five Year Forward View, the Oxfordshire Transformation Team set out its vision to change the way healthcare is delivered in the Pre Consultation Business Case (September 2016):

- Integrating primary care with specialist clinicians in the areas of maternity and paediatrics to bring services closer to patients ensuring that more patients can be managed closer to their place of residence
- Planning the delivery of more diagnostics at some local hospital sites. Staffed by multi-specialist teams to assist diagnosis and planned treatment, more patients could be treated locally and managed in the community
- Looking at urgent care provision outside hospital reducing pressure on A&E

Following the CRT meeting in September 2016, Oxfordshire decided to defer the elements relating to primary care and community hospitals to a later phase.

Immediately prior to the November 2016 CRT meeting, Oxfordshire withdrew the element relating to children's services and emergency departments.

6. Assessing the Case for change

The Oxfordshire Transformation Team provided and presented documentary and verbal information to the CRT.

Although the case for change remained the same, the scope of what the CRT was asked to review differed on Day 1 and Day 2. That said, the feedback from the first Clinical Review remains relevant to the second and both of the reviews are recorded below.

6.1 Summary of Day 1

Given the incomplete status of the documentary evidence, it had been agreed with the Oxfordshire Transformation Team that Day 1 would be treated as an interim review which would support the final work up of the case for change with the CRT acting in the role of critical friend.

In reviewing both the documentary evidence and the information shared in the verbal discussion, the CRT recognised that a significant amount of work had been carried out to develop the case for change and appreciated the need to keep the momentum going to deliver the service change required. The discussions and the outcomes of Day 1 highlighted the need for further clarity and assurance on key areas to ensure that the CRT had a clear understanding of the options to enable them to support the assurance process.

The CRT discussed in detail the principle of the vision which has been articulated within the three business cases. Members were supportive of the vision but needed further information in the following areas to enable the assurance process to be undertaken.

The key issues arising from Day 1 were summarised as follows:

6.1.2 Documentation – general:

The CRT thought that there was little cohesion between the three key documents and it was not possible to map the options from one to another to understand the co-dependencies. It would be preferred for the two business cases to be drawn together within in the Pre Consultation Business Case with the detail provided as appendices.

The Horton Business Case makes the vision for Banbury very clear but it was less clear what the impact would be on other areas of Oxfordshire. It was felt that the proposals would have more impact and would be clearer to understand if there was a holistic narrative describing proposed changes, new services, improvements and advantages from a patient perspective and broken down by geographic localities throughout Oxfordshire – the concept of geographical ‘units of care’ were discussed by the panel so that those living within a geographic location would have a clearer overall view of what the proposed changes meant to them.

6.1.3 Workstreams

6.1.3.1 Primary Care:

The CRT agreed that this work stream, although crucial to the others, was not as well developed in terms of engagement or planning and there was a need for further clarity on what is hoped to be achieved in primary care and how capacity will be created to enable primary care to take on additional responsibilities at a time of pressure. Given this, the CRT recommended that work streams proposals which relied on primary care should include mitigating actions to cover any delay.

The proposal to support primary care with expert specialist opinion could improve the quality of care for a number of patients but this has not been made explicit. The CRT requested that the proposals should set out more detail of what issues this will support and evidence how it will improve patient outcomes and experience.

6.1.3.2 Maternity

The CRT agreed that the proposal for the Horton should improve safety as current provision is unsafe on staffing levels. The CRT noted that there is a sufficient body of evidence to support the safety and quality of this model for low risk women but noted that it was essential that a sound and sustainable risk assessment process is agreed. The CRT advised that 24/7 staffing should be available at the Horton Midwife Led Unit (MLU) that conforms to national best practice guidelines and that this should not be compromised.

The CRT felt that additional modelling was required to predict future births and questioned whether the MLU at the Horton would be sustainable if a number of women chose to give birth elsewhere. They identified that there was a risk that numbers of births at the JR may grow quicker than it could expand its capacity and recommended a contingency plan. The CRT noted that the travel time between the Horton and the JR is a concern for women who may need to be transferred to the latter. The current mitigating action is an ambulance permanently on site. The CRT asked whether this is sufficient and sustainable. To support the case, Oxfordshire should make available the outcome data regarding number of women with late transfer from existing MLUs in Oxfordshire which could be benchmarked against other MLUs with a similar distance to an obstetric unit.

The CRT was concerned about the proposals for the completion of the initial risk analysis by GPs and sought assurance that there was the capacity and the skill requirement in primary care. The CRT questioned whether GPs were the right people to do the risk assessment and if records/information could be shared between midwives and GPs, would this mean that the midwives could carry out the assessment?

The CRT was concerned that there was no mention of perinatal mental health and social care. The services need to be developed with mental health and social services. Furthermore, there needs to be a strong link with mental health for post birth issues.

The CRT felt that it was important that Oxfordshire should show how the issues identified in the Independent Review Panel review in 2008 have been addressed

6.1.3.3 Paediatrics

The CRT felt that the proposal reflected up to date clinical guidelines but suggested a stepped change to a 24/7 ambulatory service. It noted that a very robust community nursing service would be required to support the ambulatory service but that evidence had been supplied regarding this.

The CRT felt that a benefit of the change would be the number of extra children that could be treated/seen at the Horton and suggested that evidence for this could be obtained.

The CRT noted that whilst there has not been much recent national policy in relation to this, there has been a radical upgrade in prevention and questioned whether Oxfordshire Public Health had been involved in the proposals.

6.1.3.4 Planned Care:

The CRT was broadly supportive of the model for planned care and there is growing evidence for the effectiveness of this model. It agreed that the proposal was acceptable on the grounds of quality, safety and sustainability but needed more detail on the use of existing facilities and noted a lack of detail regarding the physical capacity of the Horton such as theatre space

The CRT agreed that enhanced recovery would be required but may not need Level 2 and suggested that Oxfordshire review this.

The CRT agreed that the local hospital proposals offered better travel times and the one stop should improve the quality and value for patients. The CRT queried the lack of inclusion of post intervention access.

6.1.3.5 Urgent and Emergency Care

The emergency care proposals reflect current clinical guidelines but the CRT required more detail for the urgent care element to be able to assess this. It noted that gaps included 111, GP Out of Hours and pharmacy.
A number of points were raised by the CRT:

- The proposals should improve sustainability but the paper does not provide evidence for that
- More consideration needs to be given to the proposal to include the Level 2 Critical Care unit
- A link with social care is missing
- The pathway to the paediatric unit at the Horton is unclear
- Integration is not clearly enough demonstrated and there are good examples in Oxfordshire which could be used
- The proposals do consider the issues of patient access and transport but the evidence of clinical benefits has not been provided

6.1.3.6 Mental Health:

The document states that a proposal for mental health provision has been through an NHS England assessment process and will shortly be entering the procurement phase. The CRT noted this but in order to give a full picture of what and where services would be available across Oxfordshire, enough detail of these proposals needed to be included in the documentation.

6.1.3.7 Social Care

A description of the Interactions and interface with the county council was missing from the documentation and descriptions of services. The CRT requested that the documentation should explicitly mention care integration. The CRT agreed that this relationship would be key for the risk assessment and prevention elements of the proposals and the role of the county council and its relationship to the Oxfordshire proposals should be described.

6.1.3.8 Activity / Data

One of the components of the Senate assurance relates to the safety of the proposals. Insufficient information regarding the specifics of the proposals was provided including current and future patient flows, current and proposed activity numbers, staffing and outcome data from the existing services.

6.1.3.9 Organisational model and implementation

Given the scale of the proposals, the CRT requested an indication of the implementation plans and what components will be prioritised. There is currently no information on how the proposals would be delivered.

The service descriptions paint the picture of a relationship between OUHFT and Oxford Health. Recent reports in the HSJ suggest that this may not be without its problems and the CRT stated that it would be helpful if assurances of good working relationships were contained within the documentation

6.1.4 Engagement:

Public engagement: It was explained to the CRT that public engagement exercises were carried out in June and July 2016 and were ongoing. It is recommended that these are documented showing the feedback from these events and how the feedback has been incorporated into the proposals. The CRT suggested that it might be helpful to link with some public engagement groups such as Healthwatch.

GPs: It was noted that GP consultation generally is at an early stage. Given the importance of the role of primary care in these proposals, it is recommended that this is undertaken as promptly as possible so that primary care support is available during the public consultation.

Other parties within Buckinghamshire, Oxfordshire and Berkshire West STP: The CRT was unable to find evidence of engagement with West Berkshire or Buckinghamshire regarding the proposals or any potential impact on these neighbouring health systems. These interfaces should be described

Clinical endorsement: The CRT noted that this will be key for these proposals and clinical champions should be identified for each of the work streams

6.1.5 Workforce

The CRT raised queries on workforce modelling for several of the work streams

6.1.6 Health Inequalities

There was no evidence to demonstrate how the proposals would improve health inequalities

6.2 Oxfordshire response to the CRT feedback

The Oxfordshire Transformation Team responded to feedback regarding the Pre Consultation Business Case (PCBC) and advised that this is in the process of being re-written but was not available for the review in November 2016.

A case for change document was submitted which combined information from the PCBC and the Horton Business Case. It was stated that this document would look at services across Oxfordshire rather than focus on north Oxfordshire but this may not have been achieved to the level required being both hospital and north Oxford focussed. It was not clear whether this document had been produced as public facing and clarity on this is required.

The documentation presented in November 2016 was organised by work streams and was more accessible than the previously submitted documentation.

6.3 Summary of Day 2

The scope of the proposals for the CRT review in November 2016 was not the same as that put forward in September 2016. Oxfordshire had announced its intent to defer the community hospital proposals and primary care proposals to a later phase to allow more time for the development of these work streams. In addition, immediately prior to the CRT November review date, the proposals for children's services and emergency departments were also withdrawn stating a lack of clinical consensus and these elements will be reviewed and be subject to public consultation at a later stage.

The CRT on Day 2 was made up of the same members as for Day 1 with the exception of Dr Sian Butterworth who did not attend as the Children's proposal had been withdrawn.

The proposals for review on Day 2 were therefore:

- Urgent care (excluding Emergency Departments)
- Stroke services
- Planned care
- Maternity services

6.3.1 General Feedback

Whilst the reason for deferring a large part of the original proposal was understood, the CRT was concerned that this left the remainder of the proposals less cohesive. This perception was emphasised by the lack of a long term vision of the total transformation or an implementation timeline which gave evidence of the dependencies in the work streams. The submission lacked integration and did not address community / primary care workforce issues, roles transformations or work stream interdependencies.

The result of the phasing was that the review under consideration appeared to be more like an individual service reconfiguration rather than system transformation and was focussed on the north of the patch rather than Oxfordshire in its entirety.

The CRT agreed with the principles contained within the proposals but noted that the assumptions made were not evidenced in the material made available to the CRT. In particular there was no cohesive plan for what was happening outside of the hospital environment and it was difficult to be assured that the proposals would work without having sight of the community plans.

The case for change referred to 'many areas of inequalities' which had been explored in the Director of Public Health's report. These were not addressed within the proposal though it was noted that the Health and Wellbeing Board has sponsored an independent commission on health inequalities which will 'further inform how we address inequalities'. This should be addressed in the later Phase(s) of the Oxfordshire Transformation.

Evidence was provided of extensive public engagement and it was felt that this had been a good piece of work. However, it was not clear that the feedback obtained had been fully incorporated into the proposals. For example, one of the key messages from the engagement had concerned quality and the requirement for it to improve and the CRT would like to see more evidence of how this has been addressed within the proposals.

Workforce plans were not supplied in sufficient detail to allow for a robust assessment. High level indications of staffing requirements were included but training and particularly recruitment were not addressed so it was not clear how the workforce issues identified would be addressed. This may be due to the early stage of the proposals. This work needs to be undertaken and submitted.

There was very little modelling of future activity or capacity which meant that, coupled with the lack of workforce data the CRT was unable to assure itself of the effective and safe delivery of the individual service proposals.

CRT thought that the IM&T proposals could be better constructed to support a transformation programme

There was no submitted modelling on finance (even though this is a clinical review the two cannot be fully divorced). There was no indication of the cost of providing ambulatory care or the reinvestment between sectors to deliver this model

Mental health has been dealt with separately and whilst it was recognised that it had gone through a separate process, it is still important to provide enough information to show how the services are integrated. This was not available.

There was incomplete referencing to data sources.

The CRT considered the individual service proposals as follows:

6.3.2 Urgent and Emergency Care including Critical Care

The Overview document stated that the Transformation Programme Board had deferred the proposals for much of this work stream and the CRT was therefore asked to focus on:

1. The proposal to change the current Critical Care Centre at the Horton General from a Level 3 to a Level 2 Centre.
2. The proposal to realign bed numbers in order to move to an ambulatory model of care. This would formalise the temporary changes made as part of the successfully 'Rebalancing the System' project that has been running since November 2015. This project has enabled patients who no longer need acute medical care to move from a hospital setting into a nursing home. The project has allowed patient needs to be met more appropriately while they wait either to be transferred home with community-based support or to a permanent care home placement

The documentation submitted by Oxfordshire had a wider remit than is reflected in the areas the CRT was asked to focus on. The response documented here is in relation to these 2 focus areas only.

Critical Care Centre

The current Critical Care Unit (CCU) at the Horton is designated as a Level 3 and therefore expected to care for patients who need advanced respiratory support alone or basic respiratory support together with support of at least two organ systems including all complex patients requiring multi-organ failure. (*Horton Business Case)*

High level information was supplied which showed that over the last six years, the numbers of patients admitted and number of days of intubation were low and this was affecting clinicians maintenance of their skill set with these types of very sick patients. Of concern is that the Intensive Care National Audit and Research Centre (ICNARC) data for 2013/14 shows the Horton as having the lowest ventilated admissions per unit in this region but the mortality for ventilated patients is amongst the highest amongst its peers. In addition, the current vacancy rate has resulted in a failure to meet the Guidelines for the Provision of Intensive Care Services (GPICS)

- It was noted that many patients including those requiring PPCI and those with major trauma are already taken directly to the John Radcliffe
- It was agreed that the numbers of ventilated patients (equivalent to one or less per week) is too low for clinicians to maintain their skills
- It was agreed that quality could not be maintained at Level 3 but that it could be at level 2 if appropriate training is provided for medical staff
- The principle of changing the status of the CCU to a level 2 was supported provided the joint management by acute medicine and critical care services and the links with the Headington critical care units, as described in the Horton Business Case, are in place and that there is a timely process for transfer of appropriate patients to Headington

- Given the level of concern about the current mortality figures at the Horton, the CRT recommended that the existing provision be urgently reviewed
- The CRT recommended that the documentation is reviewed for the language used.

Delayed Transfers of Care (DTOC) - Rebalancing the System
In Autumn 2015, strategic work across the health and social care system in Oxfordshire led to the implementation of a project to address delays in the discharge of patients who no longer needed hospital care and to improve patient flow and experience.

The approach focussed on transferring patients who were medically fit to be discharged from hospital into beds in nursing homes across Oxfordshire while they awaited the next stage of their care. The approach was successful for the hospital moving Oxfordshire from its comparative position on delayed transfers of care from 151 out of 151 in November 2015 to 108th in September 2016. Oxfordshire is seeking to further improve on its position by formalising the scheme and increasing the number of beds in the scheme from 76 to 194.

- The documentation describing the scheme was thorough and included evidence of effectiveness
- Surveys of patients involved in the scheme showed good results
- The CRT agreed that the principle of closing acute beds to use the funding in the community was the right one but the evidence base was not sufficient to enable the CRT to comment on the number of beds that would be required
- The CRT would encourage continued investment in this scheme to the extent that the maximum potential could be achieved. It recommended that there should be checks to ensure that there is a robust system response beyond the nursing home beds to ensure that delays were not transferred from the hospital to the community

6.3.3 Stroke Services

Numbers of stroke patients in Oxfordshire is low, c800 pa. The documentation provided states that currently the majority of patients will be admitted to the Hyper Acute Stroke Unit (HASU) at the John Radcliffe though some will be admitted to the Acute Stroke Unit (ASU) at the Horton Hospital. In 2014/15, 12% of stroke patients were admitted to the ASU and these patients were identified as those whose presentation was atypical or late. SSNAP data provided identifies that the Horton performs poorly in a number of elements of stroke service.

The acute settings also host inpatient rehabilitation and therapy which is available to patients for up to six weeks. Additional stroke rehabilitation is available in the form of Early Supported Discharge services (ESD) which are available for the city of Oxford and also Bicester. The documentation identifies that while ESD is both cost-effective and clinically appropriate for many stroke patients, it is not available across many Oxfordshire localities and currently serves only half of the population of the county.

The Oxfordshire Team is planning an improvement in stroke mortality by conveying all appropriate patients to the HASU at the John Radcliffe and rolling out ESD across the county to improve patient rehabilitation and outcomes.

Oxfordshire CCG has identified five options in regard to securing stroke rehabilitation. It asked the CRT to consider whether it has identified the advantages and disadvantages of

these five options correctly and clearly and what process it might follow in order to get to a preferred option.

- The CRT identified a lack of clarity regarding the specifications supplied within the documentation which include provision of pathways to both HASU and ASUs despite a stated intention to move to the London model (HASU)
- The CRT agreed that the SSNAP data shows poor performance at the Horton and supported the principle of the move to the London model where all patients will be seen in a HASU for the first 72 hours. The only exception to this would be where a patient has other medical conditions which would make this inappropriate
- The CRT supported a proposed improvement in availability of ESD for all appropriate patients but was unable to comment on detailed plans, which were not made available
- The CRT questioned the home base of the suspected stroke patients attending the Horton and this needs to be mapped to identify whether the JR would be the closest HASU for patients attending from the borders of Warwickshire or Northamptonshire. If the JR is the closest HASU, the CRT requested information about where rehabilitation would be provided to those patients and expressed concern about potential repatriation risks to and from neighbouring counties
- There is reference to a proposal to increase the size of the HASU at the JR though no capacity planning was supplied. The CRT requested a projection of activity and capacity
- The CRT found no reference to dialogue with the ambulance service and the impact on it
- It was not feasible to comment on the five procurement options for community rehabilitiation without knowledge of the proposals for community hospitals which will be included in Phase 2. The CRT recommended that improvement in patient outcomes should be the driver for the procurement
- The CRT was concerned that those patients who have a stroke whilst in the Horton or who take themselves to the Horton are currently not receiving thrombolysis

6.3.4 Planned Care

The documentation stated that the proposal to centralise specialist services at the John Radcliffe provides an opportunity to offer more planned services at the Horton which would deliver care closer to home for the north Oxfordshire population and surrounding area.

It is proposed that an elective surgery centre will be established at the Horton with adjoining day case wards. Where numbers allow, existing Headington surgical services will be delivered at the Horton removing the need for patients and their families to travel to Oxford.

There is a vision to build a new diagnostic facility at the Horton with MRI and CT scanners, ultrasound and other equipment that would allow rapid assessment for the delivery of high quality ambulatory urgent care. It is also proposed that a new outpatient facility should be built on the Horton site with the capacity to absorb ‘thousands’ of appointments for the north Oxfordshire population currently delivered in Headington. OUHFT staff will travel to Horton to deliver the clinics. There will also be a pre-operative assessment unit providing a service to

patients undergoing elective surgery at the Horton and also those who will be having their surgery on the Oxford sites.

In addition, some services are developing detailed plans to expand their services on the Horton site eg Cardiology.

The CRT was specifically asked to consider the proposal to move more planned care to the Horton General Hospital.

- CRT was supportive of the principle of optimising the patient flows through the creation of an elective unit at the Horton and there is evidence to show the benefit of doing this
- However, it was felt that the proposal to move outpatients to the Horton fell short of the direction of travel to move outpatients into the community and if this step was taken now, it would delay a subsequent move of this activity into the community
- It was unclear what population was affected by this proposal and whether choice would be affected particularly for those patients who currently receive elective care at the Headington sites
- There was concern that this proposal would not provide equity of access across the county. Since the vision for community hospitals was not available, it was not possible to determine whether this proposal is part of a larger plan which uses the community hospital sites for elective provision for populations in other parts of Oxfordshire.
- Advantages were identified such as better clinical outcomes and safer care such as reduced infections and quicker rehabilitation but evidence was not supplied to support this
- The implementation timeline needs to indicate the timescales required to provide an MRI and CT scanner on the Horton site with identified consequences for transfer of activity
- Further assurances were required by the CRT about the level of workforce planning that had been undertaken to underpin this approach - including plans for recruitment and retention of staff, and the acceptability of rotations between sites amongst lower-banded staff.
- It seems as though option 2 has already been selected.

6.3.5 Maternity Services

Oxfordshire presented a proposal to create a single obstetric unit for Oxfordshire at the John Radcliffe Hospital, supported by freestanding MLUs in both the north and south of the county.

There is currently an obstetric unit at the Horton Hospital which has been temporarily closed due to difficulties with staffing and has been temporarily replaced by an MLU. The Special Care Baby Unit (SCBU) CBU unit has also been temporarily closed.

The obstetric unit at the Horton is one of the smallest in the country with 1,466 births in 2015/16. The Trust has been unable to recruit to the vacant posts and there is insufficient capacity at the JR to enable doctors there to cover the unit at the Horton. The proposal is

therefore to switch to a freestanding midwifery-led unit (FMLU) which will provide a service for low risk women – those assessed to be high risk will be referred to the obstetric unit at the JR and women will continue to have a full choice of place of birth.

The CRT was asked to consider this proposal.

- The CRT agreed that the proposal to change to an MLU at the Horton is well articulated. Based on what was presented, if there was no way to make the Horton obstetric unit safe on staffing, the MLU would ensure the retention of a maternity service on the site. This would be dependent on the JR obstetric unit taking a strong leadership role for the MLUs across the county
- Removal of the obstetric unit would lead to the closure of the SCBU at the Horton but the projected impact on the Paediatric Intensive Care Unit (PICU) and SCBU at the JR was not provided to the CRT
- The CRT was concerned that the proposals for the paediatric service were not being discussed concurrently with the midwifery proposals as there were interdependencies which could not be assessed
- The CRT noted that the decision on the location of the MLUs in the south of the county and the MLU at Chipping Norton would be considered within the community hospital work stream which is due for consideration in 2017. It recommended that further work is undertaken to involve women in the development of options within this work stream and that evidence from existing MLU's is shared. Currently there is no plan for engagement on viability and linkages between other freestanding MLUs across the county
- Benchmarking data would support proposals for staffing levels as well as activity and outcome forecasts. The CRT noted the lack of benchmarking across the board but specifically on freestanding MLUs.
- Further assurances were required by the CRT in respect of the level of workforce planning that had been undertaken to underpin this approach. There was clear articulation of the medical staff requirement but it was less clear for midwifery and the acceptability, to staff, of rotations between sites was unclear.
- Evidence from existing MLUs with regard to outcomes has not been supplied or used to make the case – this would be particularly useful with regard to transfers from the MLU to the obstetric unit
- The CRT did not recommend the proposed GP involvement by face-to-face appointments of risk assessments in early pregnancy. This would use numerous GP appointments inappropriately, delay midwife involvement and their early pregnancy assessment and complicates the pathway for women. An appropriate assessment should be done but by using IT solutions and joined up medical record systems.
- Provision of mental health services, including perinatal mental health, will be key. The CRT recommended that training is provided for the midwives to ensure that they can identify issues early
- The CRT noted that the ambulance sited at the Horton for emergency transfers is only for the temporary closure and requested details of what will be in place if the change is made permanent

7 Conclusions and recommendations

7.1Conclusions

The Thames Valley Clinical Senate broadly supports the principles of the proposed changes to clinical services. There are areas where it believes that further information, evidence or development work is needed to complete the plans and has consequently made a number of recommendations which, when addressed, will evidence the ability to deliver sound clinical care under the proposed model.

The issues highlighted here are broadly the same as those identified on Day 1, in September 2016, although the proposal has since been split into two phases and so some of the feedback from Day 1 will not be relevant to the current proposals and will be picked up when Phase 2 is reviewed. Whilst the reasoning for the split is understood, it has created some difficulties in assessing this proposal as the CRT was not in possession of the full transformation proposals and therefore there are concerns about making decisions now which could impact on other components yet to be reviewed. The sense of transformation was lost in the split and the Senate has recommended that a strong vision of the whole proposal is communicated.

That said, the Senate understands the level of challenge which is faced in Oxfordshire and recognises the huge amount of work which has been undertaken by the providers, commissioners and their staff to get to this point. The Senate agreed that the case for change was well made and recognised that whilst there is a need to reduce costs in Oxfordshire, the proposals are also about an intention to improve services, patient outcomes and patient experiences.

7.2 Recommendations

The CRT agreed that the case for change is clear but would like to see evidence of further work to demonstrate that the clinical model and anticipated benefits for patients are deliverable and sustainable. The decision to split the transformation proposals into two phases made it difficult for the CRT to fulfil its remit in that it did not have sight of all of the component parts.

The issues detailed in the recommendations below may not need to be resolved prior to consultation but do need to have been explored in much more depth prior to implementation. Assurance that this work is complete will need to be provided to NHS England.

7.2.1 As the Transformation Plan has now been phased, it will be important to provide an implementation timeline to show how the service implementation has been planned for both Phase 1 and Phase 2 identifying interdependencies across the entire project.

7.2.2 Given that the transformation proposals have now been split into two phases, the CRT recommends that the building programme should not be finalised or commenced until the whole programme has been assessed and assured.

7.2.3 Although it is noted that the primary care work stream will be detailed in Phase 2, it is recommended that the perspective from primary care regarding the proposals within Phase 1 is included.

7.2.4 Critical Care Unit (CCU)

The case for changing the status of the CCU was well made and the current operation was of concern. The CRT supported the proposal to change the level of the CCU to a level 2 subject to final proposals being assured before implementation. The CRT advised that these should include:

- the plans for joint management by acute medicine and critical care services and the links with the Headington CCUs, as described in the Horton Business Case
- evidence of the timely process for transfer of appropriate patients to Headington
- the mechanism for keeping a level 2 CCU at the Horton would require a different set of clinicians to be trained and competent to keep the unit current and viable – the plan to deliver this needs to be documented and agreed
- assurance that subsequent work streams in the transformation plan do not affect the proposals as submitted

7.2.5 Rebalancing the system (DTOC)

The CRT agreed that the principle of closing acute beds to use the funding in the community was the right one but the evidence base available was not sufficient to enable the CRT to comment on the number of beds that would be required.

The CRT would encourage continued investment in this scheme to the extent that the maximum potential could be achieved for patients who no longer need acute hospital care but recommended that:

- it is made explicit that people will be moved into the community beds with a plan to achieve discharge to the intended destination and OCCG should continue to monitor the outcome for these patients, their length of stay in the community beds and the usage of the beds
- there should be checks to ensure that there is a robust system response beyond the beds in the nursing homes (intermediate beds) to ensure that delays were not transferred from the hospital to the community
- that additional modelling should be presented to demonstrate the case for the number of hospital beds included in the scheme

7.2.6 Stroke

The CRT supported the principle of all suspected stroke patients going to the HASU at the JR unless clinically inappropriate (London model) subject to final proposals being assured before implementation.

- plans for the provision of county wide ESD and rehabilitation which is key to ensure the flow of patients through the HASU and to improve outcomes for patients
- documented evidence of agreement from South Central Ambulance Service

- a shared and documented understanding of risk as there are significant interdependencies throughout the whole pathway
- workforce planning to include the ESDs and rehabilitation provision
- evidence that there is sufficient capacity at the JR to manage the additional patients from the Horton
- assurance that subsequent work streams in the transformation plan do not affect the proposals as submitted

7.2.7 Planned Care

The CRT was supportive of the principle of optimising the patient flows through the creation of an elective unit at the Horton, with level 2 CCU, subject to the final proposals being assured before implementation. The CRT advised that these should include:

- evidence that access to planned care will be equitable across the county
- ongoing review of the proposal to establish additional outpatient clinics as part of the elective unit and consideration, within Phase 2, of including these within the community model
- assurance that patient choice is not reduced by the establishment of the elective unit at the Horton
- sight of the implementation plan for the phased transfer of services and the construction of the unit for the MRI and CT scanner
- an agreed workforce plan with evidence that it has the agreement of all staff affected and required to work across the two sites
- assurance that subsequent work streams in the transformation plan do not affect the proposals as submitted

7.2.8 Maternity Services

The CRT agreed that if there is no way to make the obstetric unit at the Horton safe on staffing, it was supportive of the principle to change to an MLU at the Horton subject to the final proposals being assured before implementation. The proposal to include Chipping Norton MLU within the public consultation was not included in the documentation provided to the CRT and therefore was not considered by the CRT.

The CRT advised that the final proposals for assurance should include:

- evidence of the capacity at the JR to accommodate the additional births
- evidence of the capacity of the SCBU at the JR given that the SCBU at the Horton would close
- assurance that the proposals for the MLU at the Horton will not be affected by subsequent proposals put forward for children's services
- confirmation that the JR will provide clinical leadership across the accountable care system for community support /training in high risk skills and skills drills
- additional modelling of predicted births at the Horton MLU – in the absence of this, the CRT recommends that staffing continues on a 24/7 basis

- o additional work force planning and confirmation that the rotation required has been formally agreed with staff
- o confirmation of mental health provision to support the maternity pathway
- o benchmarked evidence from existing MLUs on safety for women requiring an emergency transfer
- o confirmation of the emergency planning for women who need to be transferred to the JR whilst in labour
- o the process for carrying out the early risk assessment on all pregnant women – there is lack of evidence that this is the right solution and is sustainable and other options should be considered eg improved communication between GPs and midwives
- o assurance that subsequent work streams in the transformation plan do not affect the proposals as submitted, particularly the primary care work stream

8 References

The 67 documents provided by OCCG were reviewed.

9 Glossary of Terms

Activity	The number of patients, cases, treatments etc
Ambulatory	Care provided on an outpatient basis including observation, diagnostics, treatment and intervention
AMU	Alongside midwife led unit – sited adjacent to an obstetric unit
ASU	Acute Stroke Unit
Capacity	The volume that a service can treat
Clinical Senate	A non-statutory clinical body, working across the Thames Valley, to provide independent clinical advice to commissioners and providers
CRT	Clinical Review Team – an independent panel working on behalf of the Clinical Senate
DTOC	Delayed Transfers of Care
ESD	Early Supported Discharge
FMLU	Freestanding midwife led unit – not attached to an obstetric unit
GPs	General Practitioners
HASU	Hyper Acute Stroke Unit
Intubation	The insertion of a tube, as into the larynx. The purpose of intubation varies with the location and type of tube inserted; generally it is done to allow drainage, to maintain an open airway, or to administer anesthetics or oxygen
MLU	Midwife Led Unit
NHS	National Health Service
Paediatric Services	Service for infants, children and adolescents
Perinatal Mental Health Services	Services which are concerned with the prevention, detection and management of mental health problems that complicate pregnancy and the following 12 months after childbirth
PICU	Paediatric Intensive Care Unit - an area within a hospital setting

	specialising in the care of critically ill infants, children, and teenagers
Planned care	Services and treatments which are not carried out in an emergency, often those which patients are referred to by their GP.
PPCI	Primary Percutaneous Coronary Intervention
Reconfiguration	To remodel or restructure
Respiratory Support	A range of services from oxygen therapy by face mask, through non-invasive techniques such as continuous positive airways pressure, to full ventilatory support with intubation
SCBU	Special Care Baby Unit - specialist hospital ward or department for the care and treatment of newborn babies that are ill or premature
SSNAP	Sentinel Stroke National Audit Programme
the Horton	The Horton General Hospital. Sited in Banbury and part of the Oxford University Hospitals NHS Foundation Trust
the JR	The John Radcliffe. Sited in Headington, Oxford, and part of the Oxford University Hospitals NHS Foundation Trust
Thrombolysis	A treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs

10 Appendices

Appendix 1: Terms of Reference

The agreed Terms of Reference (TOR) is as below but as previously stated, the scope and the timeline of the review changed throughout the process. The TOR does not reflect these changes.

THAMES VALLEY CLINICAL SENATE REVIEW

TERMS OF REFERENCE

Title:	**Oxfordshire Transformation (pre consultation business case)**
Sponsoring Organisation:	**Oxfordshire Clinical Commissioning Group**
Clinical Senate:	**Thames Valley**
NHS England:	**South, South Central**

Terms of reference agreed by:

Dr Jane Barrett
on behalf of Thames Valley Clinical Senate

and

David Smith
on behalf of sponsoring organisation, Oxfordshire Clinical Commissioning Group

Clinical review team members

The Clinical Senate will recruit an independent clinical review team with the clinical expertise to respond to the topic:

The review team is likely to include:

a) Chair of the Review Team
b) Patient / citizen representatives
c) Providers: primary, secondary, community, mental health, social care, other e.g. Ambulance trust
d) Clinical experts to be determined following receipt of information detailing the key changes
e) Public Health

It is expected that a team of between 10 and 15 individuals will undertake the review. In order to ensure that the appropriate team members can be recruited, Oxfordshire CCG will share the draft Pre Consultation Business Case with the Senate as it is developed.

The full documentation, including supporting information, should be made available to the Senate no later than 23rd August 2016 – it is noted that this is prior to the final sign off by the clinical re-design team but is essential to allow time for the clinical review team to review the material.

Any changes agreed by the clinical re-design team at its meeting on the 26th August 2016, should be communicated to the Senate Manager on 30th August and an updated copy of the pre consultation business case will need to be made available by 1st September 2016 together with any additional supporting information referred to.

Aims and objectives of the clinical review

The aim of the review is to provide an independent clinical opinion as to whether there is a clear evidence base underpinning the proposals from Oxfordshire CCG and to consider whether there could be any unintended consequences on other services within Thames Valley.

In undertaking this work the clinical review team will consider whether:

i. there is robust evidence underpinning both the clinical case for change and the proposed clinical model;
ii. the relevant available evidence has been effectively marshalled and applied to the specifics of the proposed scheme
iii. there is alignment with other national, regional and local intentions

Scope of the review

The Senate has been asked to respond to the question:

Do the options being developed for public consultation provide services which will be clinically sustainable, accessible and of a high quality enhancing the patient experience.

In responding to this question, the clinical review team will consider:

- whether the proposed clinical options reflect current national guidance where relevant
- the extent to which the proposals for clinical services are supported by evidence to show equity of service and access across Oxfordshire
- whether the proposals deliver real benefits to patients
- whether there are any significant risks to patient care in the proposals

The clinical review team is not expected to advise or make comment upon any issues of the NHS England assurance process that will be reviewed elsewhere (eg financial elements of risk, patient engagement, GP support or the approach to the consultation). However, if the clinical review team felt that there was an overriding risk, this would be highlighted in their report.

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there evidence that the proposals will improve the quality, safety and sustainability of care?
- Do the proposals reflect up to date clinical guidelines and national and international best practice eg Royal College Reports?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Will these proposals meet the current and future healthcare need of their patients with the given timeframe of the planning framework
- Is there an analysis of the clinical risks in the proposals and is there an adequate plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
- Do the proposals support better integration of services from the patient's perspective?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach?

Timeline

Delivery of the timeline has responsibilities for both the Clinical Senate and Oxfordshire CCG. These are indicated in the table below and will need to be adhered to in order to deliver the work in the timeline specified:

Date	Activity	Dependencies	Impact/Risk
17.05.16	Oxfordshire Transformation Board formally requests clinical senate review		
24.05.16	Senate Council ratifies proposal		
23.08.16	CCG provides Senate Manager with case for change documentation, options appraisal and supporting information and evidence	Availability of CCG documentation & backing data/info	Delay will impact on the CRT's ability to prepare for the 5.09.16
5.09.16	Clinical Review Team meeting including face to face component with OCCG	Availability of key OCCG team members	Inability to test findings
12.09.16	Clinical Review Team Meeting		
19.09.16	First draft report sent to CRT for approval	24 hour turnaround is required	Impact on timeline
21.09.16	Draft report (V2) sent to OCCG for accuracy check	24 hour turnaround is required	Impact on timeline
23.09.16	Draft report (v3) sent to Senate Council	Availability of resource to draft the report	Potential delay
27.09.16	Thames Valley Senate Council. Draft report with Council comments sent to NHSE Gateway Review		
28.09.16	Gateway Review		
28.09.16	Final report written up and sent to OCCG		
29.09.16	Agreement re publishing		

Reporting arrangements

The clinical review team will produce a draft report which will be presented to the clinical Senate Council. The Senate Council will agree/revise the report and be accountable for the advice contained in the final report.

A copy of the draft report will be made available to the sponsoring organisation for accuracy/fact checking.

The Clinical senate council will submit the report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals. The Clinical Senate's final report will be published simultaneously with the launch of the consultation process.

Methodology

The sponsoring organisation will supply the full pre consultation business case and evidence used to develop the case.

The documentation will be reviewed as a desk top study and during two panel meetings.

The Senate Manager will draft the report and share it with the sponsoring organisation for fact/accuracy checks.

The Senate Council will issue the final report.

The report will be sent to NHS England in line with the formal reporting identified in the process. NHS England will decide whether the sponsoring organisation has met the requirements to proceed to public consultation.

Report

A draft report will be made to the sponsoring organisation for fact checking prior to publication. Due to the timescales, this must be returned within 24 hours.

The final report will be submitted to NHSE and the sponsoring organisation by 28th September 2016.

Communication and media handling

Communications will be managed by the sponsoring organisation. The Clinical Senate will publish the report once the service change proposal has completed the full NHS England process. This will be agreed with the sponsoring organisation.

Resources

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

The sponsoring organisation will provide the full case for change and background information requested and respond promptly to requests for additional information or clarification of queries.

The clinical review team may request any additional documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

Accountability and Governance

The clinical review team is part of the Thames Valley Clinical Senate and therefore complies with its accountability and governance structure.
The Thames Valley clinical senate is a non statutory advisory body and will submit its report to the sponsoring organisation.

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

Functions, responsibilities and roles

The **sponsoring organisation** will:

1 provide the clinical review team with the case for change, options appraisal and sufficient relevant background information to support/evidence the proposal in order for the clinical review team to reach its conclusions/recommendations.

   Expected background information will include, but is not limited to:

   - relevant public health data including population projections, health inequalities, specific health needs
   - activity data (current and planned)
   - internal and external reviews and audits
   - relevant impact assessments
   - relevant workforce information, current and planned, identifying how this will support the clinical sustainability of each of the options
   - evidence of alignment with national, regional and local strategies and guidance (eg NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG 1 and 5 year plans and commissioning intentions

2 provide any other additional background information requested by the clinical review team

3 respond with the agreed timescale to the draft report on matters of factual inaccuracy

4 undertake not to attempt to unduly influence any members of the CRT during the review

The **clinical senate council** and the **sponsoring organisation** will:

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

The **clinical senate council** will:

1 appoint a clinical review team which may be formed by members of the senate, external experts and/or others with relevant expertise.

   - endorse the terms of reference, timetable and methodology for the review
   - consider the review recommendations and report (and may wish to make further recommendations)
   - provide suitable support to the clinical review team and
   - submit the final report to the sponsoring organisation

The **Clinical review team** will:

1 Undertake its review in line with the methodology in the terms of reference

2 follow the national report template and provide the sponsoring organisation with a draft report to check for factual accuracies

3 submit the draft report to the clinical senate council for comments
4 keep accurate notes of meetings.

The **Clinical review team members** will undertake to

1 Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
2 commit fully to the review and attend meetings that are part of the review
3 Contribute fully to the process and to the review report
4 ensure that the report accurately represents the consensus of opinion of the clinical review team
5 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 of the clinical review team and the clinical senate manager any conflict of interest that may materialise during the review

END