NHS
Wessex
Clinical Senate

Clinical Senate Council Report on Dorset Clinical Services Review

1. SENATE CHAIR FOREWARD

The NHS needs to continually modernise and transform in order to deliver high quality care now and for future generations. Clinical senates have a unique role in supporting the NHS in enhancing quality and delivering sustainability by providing independent clinical leadership and advice.

We need to ensure that the right balance is achieved between providing accessible services for patients and carers and making sure they are provided with high quality care by appropriately trained and experienced staff.

We hope that by bringing an expert clinical voice we can contribute in a positive way to the future development of services in the Dorset which although still in its early stages of development, aims to bring about significant improvement on the current level of provision for patients.

I am grateful to Dr Forbes Watson, the Chair of Dorset CCG and to Dr Karen Kirkham and her fellow Dorset CCG Clinical Leads for inviting us to Dorset and taking the time to explain their case for change to the External Review Team and Senate Council members.

I wish to also thank all the members of the external review team who are listed in Appendices A & B of this report for giving up their considered and insightful contribution to this important piece of

work and for presenting it to the Clinical Senate Council. I thank the members of the Clinical Senate Council for their input to the final report.

My final thanks go to the Wessex Clinical Senate Support team (Appendix D) for coordinating both the review and editing this report to reflect everybody's views.

On behalf of the external review team and the Clinical Senate, I wish all those involved in these service changes every success in achieving their ambitions to develop and implement the sustainable future health and social care services for the people of Dorset.

Professor William R. Roche, Senate Chair

2. EXECUTIVE SUMMARY

The Dorset Clinical Services Review (CSR) is a review of all healthcare provision in Dorset with the aims of focussing healthcare provision on the needs of the people of Dorset, promoting prevention of illness, delivering care nearer to people's homes and producing a sustainable and affordable healthcare system for the future.

The outputs of the CSR were referred formally to the Wessex Clinical Senate Council for assurance in March 2015, as part of an iterative process prior to consultation with the public. The Clinical Senate Council had met in Dorset in March 2014 for a study day on the current and projected challenges for healthcare provision in Dorset and met again in Poole in June 2015 when Dorset Clinical Commissioning Group (CCG) presented its proposals for the future shape of healthcare provision. An external review team (ERT) was recruited in April 2015 and presented its initial findings to the Clinical Senate Council in July 2015. These were communicated to the CCG and to NHS England and these was a series of meetings with the CCG, including further Clinical Senate Council study sessions in February and April 2016. In May 2016, the pre-consultation business case was formally referred back to the Clinical Senate Council for approval and the ERT was reconvened, with substitutions where the original members were unavailable. The findings of the ERT were presented to the Clinical Senate Council on 24th May 2016 and these were discussed in detail. This report is based on those discussions and the two sets of findings of the ERT.

The Clinical Senate Council congratulated Dorset CCG on its ambition to implement whole system changes for healthcare in Dorset and recognised the extensive engagement process which it has led with clinicians in the preparation of the pre-consultation business case. It shared the CCG's aspiration that this engagement would facilitate the implementation of the final plans.

The Clinical Senate Council found that the ERT findings were comprehensive, clear and appropriate to the population in Dorset. The Clinical Senate Council welcomed the ambition to move aspects of services to community settings. The Clinical Senate Council agreed with the ERT that the CCG's proposals for the acute hospital reconfiguration were reasonable and that the preferred option for Royal Bournemouth Hospital to be the 24/7 trauma unit was also reasonable. The Clinical Senate Council recognised that the issues of isolation, access and social deprivation required that a range of services were provided at Dorset County Hospital but noted that there risks associated with sustaining an appropriate workforce. The ERT recommended the Royal College of Paediatrics and Child Health report[1] on paediatric and maternity service provision in West Dorset to the Clinical Senate Council (henceforth known as the 'combined Royal Colleges' report'[2]). The Clinical Senate Council was satisfied that implementation of these recommendations would result in the population of West Dorset having more choice for birth plans, better access to midwife-led services, safer and more sustainable services for neonates and more children being cared for out of hospital.

The Clinical Senate Council recognised that many aspects of this major reconfiguration of services would be elaborated and refined in the coming years. Nevertheless, opportunities were identified, both for the promoting of public and patient insight into the benefits of the Dorset CSR and for enhancing clinical outcomes. Salient examples included the opportunity to co-localise in-patient

[1] RCPCH Invited Reviews Programme: Design Review, Dorset Clinical Commissioning Group. April 2016
[2] As paediatrics is intimately interdependent with other clinical specialties, the review team incorporated representatives from the Royal Colleges of Nursing, Midwives, Anaesthetists, Obstetricians and Gynaecologists

cancer services with acute and critical care, to use local healthcare hubs to address health inequities, to define the pathways for the acute medical take proposed at Poole, to promote mental health and the parity of esteem and to ensure that there was cross-system planning and development of the workforce.

The Clinical Senate Council noted that the successful implementation of the project to deliver safe and sustainable healthcare was predicated upon critical interdependencies of individual components, such as delivering integrated community services so as to allow reconfigurations in the acute hospital sector. The Clinical Senate Council was of the opinion that these interdependencies should be explained to wider public in Dorset during the consultation process.

3. INTRODUCTION & PROCESS

The outputs of the CSR were referred formally to the Wessex Clinical Senate Council for assurance in March 2015, as part of an iterative process prior to consultation with the public. The Clinical Senate Council had met in Dorset in March 2014 for a study day on the current and projected challenges for healthcare provision in Dorset and met again in Poole in June 2015 when Dorset CCG presented its proposals for the future shape of healthcare provision. An external review team (ERT) was recruited in April 2015 and presented its initial findings to the Senate Council in July 2015. These were communicated to the CCG and to NHS England and these was a series of meetings with the CCG, including further Senate Council Study sessions in February

and April 2016. In May 2016, the pre-consultation business case was formally referred back to the Clinical Senate for approval and the ERT was reconvened, with substitutions where the original members were unavailable. The findings of the ERT were presented to the Senate Council on 24th May 2016 and these were discussed in detail. This report is based on those discussions and the two sets of findings of the ERT.

The scope of the first and second reviews was outlined in the terms of reference signed by NHS England, Dorset CCG and the Wessex Clinical Senate at Appendix E.

NHS England has a role to support and assure the development of proposals and the case for change by commissioners (in this case Dorset CCG).

The four tests, intended to apply in all cases of major NHS service change during normal stable operations, are:

i. Strong public and patient engagement;

ii. Consistency with current and prospective need for patient choice;

iii. A clear clinical evidence base; and

iv. Support for proposals from clinical commissioners.

In addition to these four tests, the NHS England 'Planning, Assuring and Delivering Service Change for Patients'[3] also identifies a range of best practice checks for service change proposals, these include:

i. Clear articulation of patient and quality benefits;

ii. The clinical case fits with national best practice; and

iii. An options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.

The ERT was appointed by NHS England (Wessex). For the second review, where possible, members of the ERT who had conducted the first review were re-recruited but there were some instances where this was not possible due to retirement, ill health and changes in employment or workload. Additional members were recruited to fill these gaps. All new members received a briefing from the Senate Manager to update them on the findings of the first review. Details of the membership of the ERT for the first and second reviews are at Appendices A & B.

Every document received from the CCG was made available in paper form for reference to the ERT during the day on 17th May 2016, including those for the first review and the targeted literature review undertaken by the Knowledge and Library Services of Arden and Greater East Midlands CSU to assess whether the assumptions in the Pre-Consultation Business Case (PCBC)

[3] www.england.nhs.uk/resources/resources-for-ccgs/#service-change

were supported by the research evidence. The literature review was also made available to the CCG as an appendix to the 8th July 2015 report.

Dorset CCG has set out a case for change and its preferred option for acute service reconfiguration in the public domain. The preferred option was approved by its governing body on 18th May 2016.

The CCG has yet to finalise its out of acute hospital primary community and community-based mental health models which it refers to as the Integrated Community Services (ICS) model. The ICS model is due to be published in July 2016. However the CCG has made considerable progress with its thinking on the out of acute hospital model since the first review. Some details of the ICS modelling were made available to the ERT for this review.

It was clear that the CCG plans to go out to consultation on its preferred option for acute reconfiguration but it was not clear at the time of the second review what preferred options it would be putting forward for the ICS model.

The Clinical Senate Council and ERT had to work within a very short time frame to produce this report - approximately one-third of the time made available for the first review. However, a number of the documents made available to the ERT in May 2016 had previously been made available to the ERT in July 2015 so the team felt that they were able to respond comprehensively. Clinical Senate Council membership was largely the same in July 2015 as it was in May 2016 with a few additional members. A list of the Wessex Clinical Senate Council members at July 2015 and May 2016 is at Appendix C.

The ERT reviewed the service change proposals in the report to the governing body meeting on 18th May 2016, the 'Response to the Senate Report' document dated 3rd May 2016, the Pre-Consultation Business Case (PCBC) version 3.2.2 and supporting documents against the appropriate key tests (including clinical evidence base) and the best practice checks that relate to clinical quality. The ERT produced a report and version 0.2 of that report was shared with the Clinical Senate Council on 24th May 2016. The Chair and several members of the ERT attended the meeting on 24th May 2016 at which their findings were discussed.

The Clinical Senate Council was asked on 24th May 2016 to consider the ERT's findings and to comment specifically on:

i. The comprehensiveness and applicability of the review;

ii. The content and clarity of the review and its suitability to the population in question;

iii. The interpretation of the evidence available to support its recommendations;

iv. The likely impact on patient groups affected by the guidance; and

v. The likely impact / ability of the health service to implement the recommendations.

The first version of this report was produced and shared with the Clinical Senate Council Members for comment on 27th May 2016 at the same time it was shared with Dorset CCG for 'fact-checking'. It was then updated and issued as a final version in order to meet the assurance timescales and to be published to coincide with the launch of public consultation.

4. THE CLINICAL SENATE COUNCIL CONSIDERATIONS

The Clinical Senate Council congratulated Dorset CCG on its ambition to implement whole system changes for healthcare in Dorset and recognised the extensive engagement process which it has led with clinicians in the preparation of the pre-consultation business case. It shared the CCG's aspiration that this engagement would facilitate the implementation of the final plans.

The Clinical Senate Council found that the ERT findings were comprehensive, clear and appropriate to the population in Dorset. The Clinical Senate Council welcomed the ambition to move aspects of services to community settings. The Clinical Senate Council agreed with the ERT that the CCG's proposals for the acute hospital reconfiguration were reasonable and that the preferred option for Royal Bournemouth Hospital to be the 24/7 trauma unit was also reasonable.

The Clinical Senate Council recognised that the issues of isolation, access and social deprivation required that a range of services were provided at Dorset County Hospital but noted that there risks associated with sustaining an appropriate workforce. The ERT recommended the combined Royal Colleges' report on paediatric and maternity service provision in West Dorset to the Clinical Senate Council. The Clinical Senate Council was satisfied that implementation of these recommendations would result in the population of West Dorset having more choice for birth plans, better access to midwife-led services, safer and more sustainable services for neonates and more children being cared for out of hospital.

The Clinical Senate Council recognised that many aspects of this major reconfiguration of services would be elaborated and refined in the coming years. Nevertheless, opportunities were identified, both for the promoting of public and patient insight into the benefits of the Dorset CSR and for enhancing clinical outcomes. Salient examples included the opportunity to co-localise in-patient cancer services with acute and critical care, to use local healthcare hubs to address health inequities, to define the pathways for the acute medical take proposed at Poole, to promote mental health and the parity of esteem and to ensure that there was cross-system planning and development of the workforce.

The Clinical Senate Council noted that the successful implementation of the project to deliver safe and sustainable healthcare was predicated upon critical interdependencies of individual

components, such as delivering integrated primary and community-based services so as to allow reconfigurations in the acute hospital sector. The Clinical Senate Council was of the opinion that these interdependencies should be explained to wider public in Dorset during the consultation process.

i. The comprehensiveness and applicability of the review.

The Clinical Senate Council was assured that the membership of the ERT on both occasions had an appropriate range of skills and expertise to perform a comprehensive review of the CSR proposals. The findings indicated an appropriate awareness of the demographical and geographic context as well as familiarity with national standards, directions of travel and with healthcare initiatives elsewhere.

ii. The content and clarity of the review and its suitability to the population in question

The Clinical Senate Council found that the ERT findings were comprehensive, clear and suited to the population in question. It was noted that the integrated primary and community–based services (ICS) model was still in development and that this restricted the ability of the ERT to assess this aspect of the Dorset CSR. However, the potential to use redesigned primary and community-based services to address specific locality-based health inequalities was recognised and welcomed.

The Clinical Senate Council considered that there was an opportunity to revisit the acute services model after these work streams had concluded, to assess whether some of the new integrated ways of working which were proposed *out of hospital* could be implemented *in hospital.*

iii. The interpretation of the evidence available to support its recommendations

The Clinical Senate Council agreed with the ERT that the CCG's proposals for the acute hospital reconfiguration were reasonable and that the preferred option for Royal Bournemouth Hospital to be the 24/7 trauma unit was also reasonable. They welcomed the recommendations of the combined Royal Colleges on paediatric and maternity service provision in West Dorset and endorsed their report in full. When these recommendations have been implemented, the population in West Dorset will have more choice/better access to mid-wife led services in the West of Dorset, safer and more sustainable services for neonates and more children will be cared for out of hospital.

The Clinical Senate Council endorsed the ERT's view was that there was significant potential patient benefit from the proposed separation of emergency services in the 'Major Emergency Hospital' and planned care (or booked operations) in the 'Major Planned Hospital'. These patient benefits would include: improved outcomes, patient safety, reduced length of stay and fewer cancelled operations, lower healthcare-acquired infection rates. The Clinical Senate Council

agreed with the ERT that it was possible to quantify these benefits locally as they had been demonstrated elsewhere in the UK.

It was noted that if the CCG's preferred option was implemented then Poole Hospital would become the planned care site and Royal Bournemouth Hospital would become the emergency care site. The Clinical Senate Council agreed with the ERT view was that, based on the information supplied, that this site allocation would be reasonable.

However, while the main focus at the Poole Hospital site is on Planned Care, there is intended to be some acute provision on the Poole Hospital site and a better description of this service and how it is explained to the public, should help facilitate understanding of the changes during the consultation period. The Clinical Senate Council also advised the CCG to take the opportunity to reconsider the configuration of cancer services on the Poole and Royal Bournemouth Hospital sites.

The Clinical Senate Council's understanding was that the proposed emergency care model is for Royal Bournemouth Hospital to become a *trauma unit* with twenty-four hour, seven days a week (24/7) consultant presence. Royal Bournemouth Hospital would not have a *major trauma centre* as *a major trauma centre* would require neurosurgical and paediatric surgery services to be co-located on the Royal Bournemouth Hospital site. Major trauma centres were expected to serve a

population of 1-5 million people and the local *major trauma centre* already exists at University Hospitals Southampton. Dorset County Hospital would have a *trauma unit* operating with a 14 hours a day seven days a week (14/7) consultant presence. The Clinical Senate Council urged the CCG to use the nationally prescribed definitions in its communication with the general public and staff (in italics above) [4].

iv. The likely impact on patient groups affected by the guidance

The Clinical Senate Council thought that the CCG had made progress in assessing the likely impact on patient groups affected by the guidance. Completed equality analysis forms for the work streams had been provided[5,6,7,8,9]and a completed equality assessment form for out of acute hospital care[10].

The Clinical Senate Council observed that there was a growth in population in the urban areas of Dorset and a decline in the population of the rural areas, which could affect the sustainability of Dorset County Hospital in the longer term and was supportive of the CCG's plan to design different ICS services to meet these local needs.

[4] https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-d/d15/

[5] Evidence 5: Maternity and Family Health
[6] Evidence 6: Integrated Health and Social Care Locality Teams, Long Term Conditions, Frail and Elderly,
[7] Evidence 7: Urgent and Emergency Care
[8] Evidence 8: Planned and Specialist Care
[9] Evidence 9: Mental Health Acute Care Pathway
[10] Evidence 10: out of hospital services

The Weymouth ‘hub’ was designed to meet the specific needs of that population and the Clinical Senate looked forward to hearing how the other ‘hubs’ would be designed to specifically meet the very different needs of (for example) the Sherborne and the Boscombe populations. It is important for the commissioners to have an understanding of the impact of the reconfiguration on inner city and rural localities where there were probably already inequalities on service provision. In inner city Southampton, for example, the incidence of COPD was 60% higher than in other populations. There are inner-city communities in Poole and Bournemouth and rural isolated communities in North Dorset whose needs need to be similarly addressed by the ICS and imaginative in-hospital models.

The Clinical Senate Council noted that the ERT still had unanswered questions about the mental health and integrated community services work streams because these plans had not been finalised in time for the review. So, at the time of the review, there was an absence of analysis of the current position of how many packages of social care are outstanding, how many delayed discharges there were, what gaps in rehabilitation services there were and how the new ICS model would improve the position. Pathways had been developed but in the absence of a finalised ICS model, the Clinical Senate Council was not able to state that the modelling on future use of community hospitals (a potential to reduce from 13 to 6-7 strategically located sites has been

identified) or the assumptions that hospital activity would reduce based on new primary and community care 'hubs' was reasonable.

v. The likely impact / ability of the health service to implement the recommendations

The Clinical Senate Council recognised that implementation of the CSR and of the recommendations of the ERT would require the coordinated delivery of change in the acute hospital, community and primary care sectors. It welcomed the inclusion of local government services in the ongoing ICS work programme.

The Clinical Senate Council noted that there are national shortages in some staff including A&E consultants, GPs and community nurses particularly community paediatric nurses. They noted the ERT's concerns about the ability to recruit staff particularly in the West of Dorset. However, the successful delivery of patient-focussed service changes, network working, enhanced skill mixes and the targeted implementation of telemedicine should all contribute to successful implementation.

4. OPPORTUNITIES

The Clinical Senate Council noted that the CCG had addressed most of the recommendations from the first review (report published 8th July 2015). However, the Clinical Senate Council

consideration was that the CCG had opportunities before, during and after public consultation to make progress on the following issues:

4.1. The impact of the out of hospital (ICS) model on the number of hospital beds required – the ICS model will not be finalised until July 2016 so the Clinical Senate Council was unable to reach a conclusion on this;

4.2. The desirability of co-location of in-patient radiotherapy, acute oncology and emergency and critical services on the same hospital site. The current plan is for Poole Hospital to retain radiotherapy and acute oncology and for Royal Bournemouth Hospital to provide emergency services;

4.3. The sustainability of acute services at Dorset County Hospital;

4.4. The provision of acute medical care at Poole Hospital in addition to GP-led urgent care centre

4.5. The implementation of the parity of esteem agenda –the mental health model will not be finalised until July 2016 so the Clinical Senate Council was unable to reach a conclusion on this;

4.6. Workforce planning;

4.7. How the CSR will be implemented (the ability of the acute care collaboration vanguard to implement the model, the link with the Dorset Sustainability and Transformation Plan and risk assessment of partial implementation); and

4.8. How the change is explained to the general public.

The services on each site in the new model were summarised in the paper to the CCG Governing Body on the 18th May 2016, but neither the ERT nor the Clinical Senate Council were clear where vascular services would be provided in the new model or what the implications of the new model were for other specialised services currently provided in Dorset.

4.1. The impact of the Integrated Community Services Model (ICS) on the number of hospital beds required

The Clinical Senate Council commended the CCG on the progress in their thinking about the Integrated Community Services (ICS) model, which was impressive as a concerted effort had been made by the CCG to completely redesign of out of acute hospital, primary, community, social care and mental health services to better meet the needs of the Dorset population.

The Clinical Senate Council endorsed the ERT view that once the potential for delivery of services out of hospital in the hubs and in community hospitals had been fully assessed, then there was an opportunity to reconsider the number of beds proposed in the acute settings and the percentage reduction in hospital activity expected as a result of the reconfiguration (25% non-elective and 20% reduction elective).

Although there was also an opportunity to further explore the potential for the use of community hospital beds as step up or step down beds and to further explore how to best use and staff

community-based urgent care centres, the Clinical Senate Council would encourage the ambition to support patients to return directly to their original abode after an episode of hospital care.

The CCG has taken considerable steps to think through what is needed to provide health and social care across the whole system, aligning with Local Authorities, Health Education England (Wessex) and other organisations.

In the targeted literature review, evidence was found that a 35%-55% reduction in acute bed numbers had been achieved elsewhere with additional investment in primary and community care. The number of beds required in the future was dependent on the new service configurations in the ICS model. A dis-investment plan for the acute hospitals was needed and any reduction in acute service activity would need to be supported by new pathways in the community.

The Clinical Senate Council noted that the number of beds on each of the acute hospital sites had yet to be confirmed. The national UK average for the number of hospital beds was 3 per 1000 people in 2011. It was noted that comparison between Dorset with other parts of the UK with similar demographics and services would inform the consultation process.

There is an opportunity to undertake further detailed capacity modelling and forecasting, to clarify the impact would be of the change in the number of beds across the whole system on patient

flows within Dorset and on neighbouring Trusts and also how risks of partial implementation (e.g. Royal Bournemouth Hospital increases capacity but Poole Hospital fails to decrease capacity within the same timescales) would be mitigated. Table 1 below sets out the bed numbers that the ERT discussed:

Table 1 – Bed Numbers before and after

Hospital	**Bed numbers at present**	**Bed numbers per 1000 people in 2016**	**Proposed bed numbers (range supplied)**	**Bed numbers per 1000 people in 2025**
Poole (as Major Planned Hospital)	654		180-300	
Royal Bournemouth (as Major Emergency Hospital)	741		900-1,100	
Dorset County Hospital	415		320-360	
Community Hospital Beds	301[11]		139[12]-301[13]	
Total	2111	3	1539-2061	2-3

[11] Excludes 12 Mental Health Inpatient Beds at Weymouth Hospital

[12] There are 13 community hospitals in Dorset currently. The CCG has not yet confirmed how many community hospital beds it is proposing there would be in the new out of hospital model. Initial modelling has suggested that as few as 6 strategically located sites may not reduce journey times for more than 5-10% of the general public. This figure has been calculated by dividing the number of community hospital beds by 13 and then multiplying by 6

[13] This figure is based on the assumption that community hospital bed numbers stay the same.

The ICS model would not include specialist mental health but would include primary mental health and management of long term conditions (including mental health). It would not include specialist dementia services. The Clinical Senate Council considered that this model would assist with the delivery of the parity of esteem agenda out of hospital.

The Clinical Senate Council believed that there was an opportunity in the ICS model to describe how a number of new care pathways including long-term conditions and frail older people in Dorset would impact on the acute hospital model.

In the report of the first review, the ERT noted that there was evidence in the targeted literature review that the introduction of community geriatricians could reduce hospital admissions for frail older people by up to a quarter. Another study showed that high quality clinical decision making around the time of admission plus sufficient capacity in community services could reduce hospital admissions by 21-32% and a model whereby the community matron and social worker put together care plans in partnership similarly reduced hospital bed days in the over 65 population by 40%. The impact of these initiatives in Dorset would depend on what already had been achieved to avoid hospitalisation of the older person, but there is considerable potential to develop a primary and community care model which reduced admissions and the length of hospital stay.

The ERT were not aware of the clinical evidence base which would support a self-referral chest X-ray screening service.

The Clinical Senate Council endorsed the ERT's view that there was considerable potential, as yet unmet, to explore new pathways in the documentation for those requiring end of life care given that there is evidence that 80%[14] of health and social care expenditure is spent on patients in their last year of life. There is an opportunity for the ICS model to incorporate end of life services, with modelling based on expected numbers of deaths and to assess what capacity in the community there would be to support patients at the end of their lives at home, in hospices or nursing homes. There is an opportunity to clarify what the plans were for promoting advanced care planning including the third sector to prevent unnecessary admissions in this patient group e.g. from nursing homes.

The Clinical Senate Council welcomed CCG plans to incorporate social care and voluntary and third sector workforce modelling data to inform their future role as part of the ICS teams. Local authority or the NHS commissioned beds in care homes should be included in the modelling and also the option to use nursing home beds as an alternative to community hospitals where appropriate.

[14] Patients in their last year of life account for 80% of the Federal Medicare Programme expenditures, half of it by those in their last two months of their life. This includes health care, prescribing costs and social care. There is no comparable data from the UK but in the United Kingdom about 20% of hospital bed days are covered by end of life care. Extrapolated from 'The potential cost savings of greater use of home- and hospice based end of life care in England by Evi Hatziandreou, Fragiskos Archontakis, Andrew Daly in conjunction with the National Audit Office 2008.

The Clinical Senate Council noted that Local Authorities already face significant financial challenges and these were expected to escalate in the future. It was not clear how sustainable the social, private and voluntary services in Dorset were and whether investment or market development plans existed for them. There was an opportunity to address this and to assess the availability of good residential and nursing home provision in Dorset before the ICS work was completed in July 2016.

Further work was needed nationally to incentivise the alignment or pooling of health and local authority commissioning budgets to benefit patients more and provide more incentives for change across the whole health and social care system.

4.2. The desirability of co-location of Radiotherapy, Oncology and Emergency Services on the same hospital site

The Clinical Senate Council noted that the model proposed was for a networked Dorset Cancer, Radiotherapy, Chemotherapy and Oncology Service to be provided from the Poole hospital site with major emergency services provided at the Royal Bournemouth Hospital site.

The Clinical Senate Council welcomed the aims of the model which was for the cancer service to be delivered close to home where possible and to improve access to radiotherapy and

chemotherapy. The ERT had noted that there was a national shortage of radiotherapists, physics staff, and clinical oncologists so workforce plans which would need to be in place to address the sustainability of the new model. Radiotherapy services in the model proposed for cancer services would be provided from LINACS (linear accelerators, the machines most commonly used to deliver external beam radiotherapy treatment) at Poole Hospital and Dorset County Hospital.

The Clinical Senate Council's advice was that acute oncology should be co-located on the same site as acute and intensive care. This was based on the need to manage patients who presented acutely with malignancy or the complications of therapy together with the need for intensive care for critically ill oncology patients. In particular the Senate Council heard convincing evidence that patients requiring in-patient radiotherapy, such as those with upper aerodigestive tumours and cerebral metastases, should be in a facility that could provide the services of an acute emergency hospital. The Senate Council believed that separation of these treatment facilities from the services of an acute emergency hospital could be a regressive step with significant risks to patient safety and to the sustainability of the Dorset cancer service.

The Clinical Senate Council received information from NHS England Specialised Commissioning on the current replacement plans and proposed location of the LINACS in Dorset. One of the four LINACS currently at Poole Hospital was due to be replaced by a new unit at Dorset County Hospital in 2017 and this would be supplemented by a second LINAC at Dorset County Hospital

funded from private donation. The remaining three LINACS at Poole Hospital would need to be replaced in the next five years.

The Clinical Senate Council strongly recommends that the opportunity of the required LINAC replacements be availed of to provide comprehensive in-patient oncology services on the Major Emergency Hospital site as well as local facilities for ambulatory treatments. As Royal Bournemouth Hospital is the CCG's preferred option for the Major Emergency Hospital, this could be implemented in the context of the building work that would need to be undertaken on the Royal Bournemouth Hospital site to accommodate the services to be relocated there.

The Clinical Senate Council received advice from the Chair[15] of the External Review Team (who has played a leading role in improving cancer outcomes over the last 20 years) on the clinical co-dependencies that had been taken into account in service reconfigurations proposed elsewhere in the UK. Patients currently receive acute oncology and planned oncology services at Poole Hospital and this co-location of acute oncology and planned oncology services was a desirable service co-location which should be replicated in the new model of acute service reconfiguration.

[15] Jane Barrett chaired the External Review Team for the Dorset Clinical Services Review. She is currently the Chair of Thames Valley Clinical Senate. She qualified in medicine from Bristol University and moved to the Thames Valley in 1980. She trained part-time in Clinical Oncology in Reading, Oxford and Paris and was a Consultant Clinical Oncologist at Berkshire Cancer Centre Reading 1991-2013. She was the Medical Director of Thames Valley Cancer Network from its inception in 2001 until 2007. Over the last 20 years, Jane has played a leading role in cancer Improving Outcomes Guidance working with Mike Richards, Bob Haward and NICE as well as serving on the National Radiotherapy Advisory Group and its subsequent Implementation Group (NRIG) and on the National Chemotherapy Advisory Group, NCIG and the National Cancer Strategy Board. Jane has had a long association with The Royal College of Radiologists and was elected its President in 2010 the first from the Faculty of Clinical Oncology to be elected by the Fellowship and the first woman President from the Faculty. She was awarded the O.B.E. in 2014 for services to Radiology. She now is a strategic advisor to the North of Scotland and to Hampshire Hospitals NHS Trust for cancer services and also chairs Hospital inspections for the Care Quality Commission.

The Clinical Senate Council noted that the ERT had received no details about the chemotherapy service and were not clear where would it be delivered beyond the reference that 'chemotherapy would be more readily available in community'.

4.3 The sustainability of acute services at Dorset County Hospital

Whilst the Clinical Senate Council recognised the need for a trauma unit in West Dorset at Dorset County Hospital, they had concerns (which were also voiced in the first review) about whether it would be possible to staff the new model given current and future workforce availability. An example was A&E where the introduction of a 24/7 model across two sites would increase the staffing requirement.

The ERT discussed the intention for a consultant rota across three sites and whether this was practical given the distance from Poole to Dorset County Hospitals. A question was posed as to how attractive these network roles would be to scarce A&E consultants. It was noted that there was a national shortage of A&E consultants. The ERT discussed whether it would be possible to adjust the rota (say to work two half-shifts in different locations) to achieve this, but noted in the A&E example that there could be problems with on call commitments if the pressure rose in the

place the consultant had just left and there was a risk of it overwhelming the clinical resource available.

There were also concerns raised about the ability of Dorset County Hospital to staff the obstetric-led maternity service and paediatric service in the short term.

In the PCBC, there was as yet no information on the number of operations per surgeon by specialty so the ERT did not know whether the surgeons had sufficient cases to meet Royal College guidelines in the current or new model. There was also no modelling of current and future hospital activity in the PCBC with a few exceptions (stroke).

The ERT also had concerns that Dorset County Hospital would be unable to sustain the level of trauma, neonatal and paediatric services planned given staffing constraints and the population/catchment numbers, but noted that it is a requirement of a trauma unit that TARN data has to be submitted so the quality and safety of this service could be monitored through the CCG assurance process on an ongoing basis. Similar monitoring could be introduced for neonatal and paediatric services.

The Clinical Senate Council noted the CCG's proposals to continue to provide elective and emergency cardiology services at Dorset County Hospital and observed that given the geographical and transport considerations, this seemed appropriate at the time of review, provided that the clinical outcomes remain good. In the longer term, the relatively low number of patients with heart attacks requiring angioplasty may conflict with national guidance on minimum case numbers per hospital and the benefit of timely local treatment will need to be weighed against the risks of being transported to a larger but more distant centre.

The Clinical Senate Council noted the ERT's concerns that on weekdays there would be three sites providing assessment for urgent and routine referrals for Transient Ischemic Attacks (TIA) or 'mini-strokes': one in East Dorset, one at Dorset County Hospital Foundation Trust (DHFT) and one at Salisbury Hospitals Foundation Trust (SHFT). In contrast: "at the weekend one site would provide the TIA service, rotating with SFT so 2 in 3 weekends there will be a service in Dorset". The ERT was informed that this was how the service was provided at present but observed that there were risks in the operational practicalities that this posed for the ambulance service and noted that there was a national desire (but not yet a guideline) for a three-hour time to treatment for stroke patients. The Clinical Senate Council thought that there was an opportunity to provide the TIA service remotely using telemedicine and asked the CCG to appraise this option (as it had been implemented in remote and offshore areas of Scotland) as well as communicating further with the ambulance service.

In mitigation of the risk that the trauma unit will be unsustainable due to staffing constraints, the Clinical Senate Council accepted the ERT advice to the CCG that they consider an alternative model as a back-up plan or 'Plan B': the use of air ambulance with medical support and/or advanced practitioners.

In mitigation of the risk that maternity, neonatal and paediatric services will be unsustainable due to staffing constraints, the ERT advised the CCG to pursue the option of integration with the east and move to the network model simultaneously for maternity and paediatric services.

4.4. The provision of acute medical care at Poole Hospital

The model for Poole Hospital was for it to have a local emergency service, which the CCG refer to as an "urgent care centre" staffed by GPs and Advanced Practitioners. However, there was also a reference to 'sub-acute medicine'. The Clinical Senate Council noted the comment of the ERT that GPs do not deliver acute medicine so there would be a need for consultant presence at Poole Hospital for the acute medically ill patients.

The Senate Council's view was that there was an opportunity to further describe the model proposed for Poole Hospital with particular reference to (consultant) medical care input. The Clinical Senate Council agreed with the ERT recommendation that a significant proportion of an

'acute medical take' could be catered for at a local hospital (based on the Lymington Hospital experience). It was felt that the figure of 30% quoted for 'acute medical take' was conservative and questioned the use of the term 'sub-acute medical' admissions.

4.5. The implementation of the parity of esteem agenda

The vision that the Five Year Forward View (FYFV) set out when it was published in October 2014 was that the NHS would take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care.

The Clinical Senate Council noted that the ICS model would not include specialist mental health but would include primary mental health and management of long term conditions (including mental health). It would not include specialist dementia services. The Clinical Senate Council considered that this model could be flexed to assist with the delivery of the parity of esteem agenda out of hospital.

The CCG's Mental Health work stream had just commenced at the time of the first review. A number of acute care pathways have now been provided, outlining access to care in a crisis and current NHS England priorities such as Dementia and Child and Adolescent Mental Health Services. The Clinical Senate Council noted the fact that the ERT commended the CCG on the quality of the work on mental health services, but shared the ERT's concern that mental health

had been a separate work stream in the Clinical Services Review which perpetuated 'silo' working and that the work on mental health services transformation had yet to be completed - with a strategic business case due in July 2016.

The Clinical Senate Council noted the ERT's observations that there had been excellent work undertaken by the CCG with regard to primary and community-based services in this area, but felt that the acute 'in-hospital' model did not break down barriers to the same extent as the ICS 'out of hospital' model. There was an opportunity to revisit the acute hospital model and seek assurance from the acute providers that there is indeed 'no health without mental health'. Dorset has the third highest number of people recorded on the GP register with severe mental illness in Wessex (behind Southampton and the Isle of Wight) and Bournemouth has a persistently high number of drug-induced deaths per annum.

There was an opportunity in the ICS model to achieve a significant improvement in patient outcomes by adopting a local multi-disciplinary multi-professional integrated health and social care team approach across mental, and physical health services (including sexual health and substance misuse services) and there was a concern now voiced that the acute hospital model was lagging behind by not considering similar radical ways of working on each of the acute hospital sites.

4.6. Workforce Planning

The CCG has outlined in part what the models of care would look like to deliver in terms of workforce, estates and numbers. An additional level of granularity has been provided but the workforce data was still being refreshed. There was no information on the age profile of the workforce – this may pose a significant risk if a proportion of the workforce is nearing or over 55 for whom this could be one change too many. The workforce plans need to be developed to include detailed numbers, types and ages of staff and mitigation of such risk.

There was an opportunity across the CSR to provide further clarity on the numbers of staff needed by type, what steps needed to be put into place for recruitment and retraining and which area or staff group needed to be focused on first. There was also an opportunity to provide further clarity on the numbers and type of staff who would be retrained with an assessment of what the potential was for retraining.

It was noted that, although the professions were listed in the ICS documentation by current title (practice nurse, community nurse etc.), in the future model they will be nurses in integrated teams in a 'hub' working with federated GP practices. The allied health professional (AHP) role was being considered as part of the ICS model. The Clinical Senate Council endorsed the ERT view that there was potential to boost rehabilitation services in patients own homes to improve outcomes and reduce readmissions.

The Clinical Senate Council welcomed CCG plans to incorporate social care and voluntary and third sector workforce modelling data to inform their future role as part of the ICS teams. There was also an opportunity to include local authority and NHS commissioned beds in care homes in the modelling and also to consider the option to use nursing home beds as an alternative to community hospitals where appropriate.

The Clinical Senate Council identified the need to implement cultural change in the current and future workforce, in terms of realignment of staff loyalties from institutions to the wider community of people in need of services. This will be critical for the successful implementation of networked working and a development programme for this change should be included in the plans.

There was an opportunity to spell out how school nurses, health visitors, other local authority commissioned services and the third sector fit into this model. Their ongoing role as part of the wider primary care team and as part of the wider children's workforce and the assessment of the implications of the transfer of responsibility for commissioning this service to Local Authorities could deliver significant patient benefit.

There was an opportunity to clarify the need for specialists and generalist nursing in the community: the ERT had noted that the success of the management of diabetes patients in the

community depended on whether that patient was seen by a specialist diabetic nurse in the practice. The ability of the CCG to manage half of the diabetic patients in practice rather than send them to outpatients would therefore depend on access to specialist nurses in the community.

Once the ICS model was complete there was an opportunity to produce a workforce strategy and investment plan for primary and community services so that the general public can understand better the changes proposed for primary and community care and what incentives the CCG would use to achieve the changes required over the next five years. The new model would require changes in the primary and community care workforce in terms of numbers of staff required and new types of roles needed. The CCG should work closely with Health Education England (Wessex) to achieve this. The CCG was aiming to finalise the ICS model by July 2016.

The Clinical Senate Council noted that there are national shortages in some staff including A&E consultants, GPs and community nurses particularly community paediatric nurses. They noted the ERT's concerns about the ability to recruit staff particularly in the West of Dorset. However, they believed that there was an opportunity to consider imaginative options for the delivery of those services to mitigate this by working closely with Health Education England (Wessex) on the development of new roles and consider new incentives (such as bursaries for training and increased pay). They also noted that there was an intention to shift acute nurses into community settings: this would have many implications in terms of need for retraining, skill mix, willingness of

staff to change role, the desirability of the job role, pay and off-site supervision but would also have considerable benefits in the retention of experienced staff and the ability to care for very frail people in their own homes, avoiding admission to hospital.

It was not clear what 24/7 meant for community services and if in fact it was needed. There were questions about staff consultation and as yet it was unclear whether hospital or community staff members were aware of what was proposed in the ICS model.

The Clinical Senate Council noted that 'My Health My Way' was commended by the ERT for promoting self-management and providing encouragement to those who are already motivated. The Clinical Senate Council thought that there was an opportunity for the ICS model to provide additional support for those people who are not motivated or who are struggling to make changes to their lifestyles. The behavioural change interventions have been described but not yet applied to the modelling so there is an opportunity to assess how much demand they would take out of the system.

It was acknowledged that some of the job roles needed were new e.g. the future health service will require staff who can treat both physical and mental illness. The Clinical Senate Council advised the CCG to work closely with Health Education Wessex to pilot some of these roles as soon as

possible. Inducements may be needed to attract staff to work in certain locations beyond the opportunity to train in different settings (although this initiative was welcomed). The Clinical Senate Council believed that there is an opportunity to start this work now and there is a need to proceed at risk – this work stream should not be stalled by the consultation process - as it takes time to grow new or different staff.

The Clinical Senate Council welcomed the fact that the CCG is considering new roles as part of ICS such as peer support worker and advocate roles – these are likely to be peer experts and some will have experience of using health and social care services. There was an opportunity to consider new roles in the acute setting also. The Clinical Senate Council noted that it is important to test or pilot these new roles as ERT members had some concerns about the extent of the peer support worker and advocate role as described in the documentation - the role as described in cancer services seemed to be similar to the specialist cancer nurse role at present.

4.7. How the Clinical Services Review will be implemented (the ability of the acute care collaboration vanguard to implement the model, the link with the Dorset Sustainability and Transformation Plan and risk assessment of partial implementation).

The Clinical Senate Council heard that the NHS did not make it easy for the general public to understand where to go when they need treatment. This has the result that there are people who

attend local emergency and trauma units who do not need to do so. The ERT heard that minor injury units were underused in Dorset. The CCG has an opportunity to develop a coherent plan and communicate it to the public in simple terms and some of these changes could be implemented now, so that there is capacity later to 'scale up' services at Royal Bournemouth Hospital in a phased way.

The Clinical Senate Council endorsed the recommendation in combined Royal Colleges' report on paediatric and maternity service provision in West Dorset that an urgent decision should be made within six months to integrate services between Dorset County Hospital and Yeovil District Hospital resulting in one site delivering consultant-led obstetric care and one site with a midwifery led unit, one site delivering an inpatient paediatric service and the other site with a paediatric assessment unit.

The Clinical Senate Council endorsed the ERT's advice to the CCG to pursue this option and the integration with the east and move to the network model simultaneously, noting the ERT's concern that Yeovil Hospital had issued a public statement, which said 'whilst the report does suggest opportunities for making changes to maternity and paediatric services in our hospital, we have discussed these in detail with Dorset CCG, Somerset CCG and the authors from the Royal

College and at this stage have concluded that there is not currently a case for change which represents the best interests of our entire patient population in Somerset and beyond.''[16]

The Clinical Senate Council thought that there was an opportunity to undertake further work prior to implementation with South Western Ambulance Services (SWAS) to assess the impact of increased journey times on the availability of ambulances as modelling elsewhere had shown a considerable impact.

At the same Clinical Senate Council meeting on 24th May 2016, the draft Sustainability and Transformation Plan for Dorset was also discussed. It was noted that Dorset CCG together with local government partners is considering the formation of one integrated health and social services body for Dorset as is taking place in other communities (such as Manchester, Cornwall and Liverpool) and is examining the potential benefits of this type of accountable care model for the patients.

Neither the Clinical Senate Council nor the ERT had seen a detailed analysis of the risks of partial implementation and therefore expected that it would emerge from the consultation process. There was an opportunity to create a clinical risk assessment across the whole system, given the scale of the change and the potential impact if only part of the vision was achieved, on quality of care

[16] http://www.dorsetecho.co.uk/news/14432277.Hospital_claims_service_mergers_is__not_in_best_interests/

during the transition and on the sustainability of the whole plan. The scale of the change is such that if it were not implemented in full, there would be significant pressures on parts of the system that could result in service failures.

4.8. How the change is explained to the general public

The Clinical Senate Council recognised how important it is that the key messages have been, and will be, communicated accurately to the general public and staff. Experience elsewhere has shown that within the local population, some will perceive themselves as “winners” and others as “losers” as a result of these proposals. It will be crucial that the concerns of the perceived “losers” are acknowledged and addressed directly: that communication and engagement activity ensures any misconceptions about actual impact are corrected: and that the proposals are seen in the context both of securing the best outcomes for the whole population and securing equal access for all.

The Clinical Senate Council noted that is important to accurately describe how the services were performing at present, even if this is uncomfortable, in order for people to be able to assess the potential benefits of the change. For example: there is information on how Dorset CCG is performing on a range of targets in comparison to the best CCGs in the country which could be used as a starting point. Also, the ERT heard that services in Dorset all have different criterion for

admission so the opportunity to standardise the response in line with best practice and the anticipated improvements in outcomes and access could be articulated.

The Clinical Senate Council recognised that there is a challenge to describe accurately what the local emergency service would provide as it was believed that the expectation of the general public was that every A&E department is the same. The ERT noted that the provision of minor injuries services have not yet been reviewed and observed that the challenge is staffing them with people with the right skills. There is no minor injuries unit at Royal Bournemouth Hospital currently so a large number of people with minor injuries go to A&E. The Clinical Senate Council thought that there was a potential benefit to the early resolution of this issue.

The Clinical Senate Council was encouraged by the relayed information that Dorset had a high uptake of the summary care record. The CCG's decision to introduce a Dorset Health Record was welcomed. The ERT had noted that this could be a valuable tool for the management of care out of hospital. The fact that the record will be a resource for the integrated teams was a local benefit, but it would require regular auditing to make sure that the information was used by the right professional in the right place at the right time. The importance of consent was highlighted and the ERT had noted that there was potential for confusion at present with a Dorset Health Record, Summary Care Record and an Enhanced Summary Care Record all in operation or proposed for the Dorset population.

There was an opportunity to explain in clear terms what might be the potential benefit from the single point of access in Dorset. At present, it is impossible for patients to access acute services other than via A&E departments in some hospitals. Another local potential advantage was the fact that 999, 111 and out of hours services were all managed by the same provider (SWAS) so the opportunity for improving access by diversion or sign-posting to the right professional in the right place at the right time was there. This data which was held by SWAS had not yet been interrogated in the documentation provided to assess the potential for improvement.

The ERT had not yet seen information on what services patients could expect to receive from social care/primary care/community services/hubs/community hospitals/acute hospitals to demonstrate how the proposed whole system model was different from what was currently available but had some confidence that this would be available when the ICS model is complete. An investment plan for out of hospital services was needed to assure the sustainability of the clinical services.

APPENDIX A

ERT Membership (First Review Team)

	Role	Name	Title	Organisation
1	Chair	Jane Barrett	Chair	Thames Valley Senate Council
2	CCG	Cathy Winfield	Chief Accountable Officer	North West Reading CCG/South Reading CCG/Newbury and District CCG/Wokingham CCG
3	Health and Wellbeing Board member	Andrew Mortimore	Director of Public Health, Southampton City Council	Southampton City Health and Wellbeing Board
4		David Phillips	Director of Public Health, Dorset	Dorset County Council
5	Health watch	Martyn Webster	Manager	Dorset Health watch
6	Patient	Jenny Stiling	Patient	Wessex Patient Voice Project in collaboration with the five Health watch organisations
7	GP	Tim Wilkinson	GP, Derby Road Group Practice, Portsmouth.	Portsmouth City CCG

	Role	Name	Title	Organisation
8	Nursing – Cancer/End of Life	Alison Keen	Head of Cancer Nursing	University Hospitals Southampton
9	Nursing - Maternity	Caroline Brunt	Consultant Midwife	Hampshire Hospitals
10	Social Services	Clare Hooke	Strategic Service Manager	Hampshire County Council
11	Mental Health	Dr Femi Ogeleye	Consultant Psychiatrist	Southern Health Foundation Trust
12	Medical - General Surgery	Karen Nugent	General Surgery Consultant	Southampton University Hospitals Foundation Trust
13	Medical - Accident and Emergency	Kelvin Wright	Consultant Critical Care & Emergency Medicine	Frimley Park Hospital Foundation Trust
14	Medical – Long Term Conditions	Partha Kar	Consultant Diabetologist	Portsmouth Hospitals Trust

	Role	Name	Title	Organisation
15	Public Health	Mary O'Brien	Consultant in Healthcare Public Health	Public Health England
16	Therapist	Hayden Kirk	Consultant Physiotherapist/ Clinical Director	Solent Health Care NHS Trust
17	National Medical Director's Clinical Fellows	Olivia Jagger	Fellow/GP in Southampton from August	Health Education England
18		Louise Southern	Fellow/most recently Care of the Elderly Registrar	
19		Clare Smith	Fellow/ Paediatric ACF	

APPENDIX B

ERT Membership (Second Review Team)

	Role	Name	Title	Organisation
1	Chair	Jane Barrett	Chair	Thames Valley Senate Council
2	CCG	Sue Lightfoot	Head of Commissioning Mental Health & Learning Disability	Isle of Wight CCG
3	Health and Wellbeing Board member	Bob Coates	Interim Director of Public Health, Southampton City Council	Southampton City Health and Wellbeing Board
4	Healthwatch	Martyn Webster	Manager	Healthwatch Dorset
5	Patient	Jenny Stiling	Patient	Via the Wessex Patient Voice Project in collaboration with the five Health watch organisations
6	GP	Michelle Chester	General Practitioner/ Cancer Lead GP	CRUK
7	Nursing – Cancer/End of Life	Alison Keen	Head of Cancer Nursing	University Hospitals Southampton

	Role	Name	Title	Organisation
8	Social Services	Clare Hooke	Strategic Service Manager	Hampshire County Council
9	Mental Health	Dr Femi Ogeleye	Consultant Psychiatrist	Southern Health Foundation Trust
10	Medical - Accident and Emergency	Kelvin Wright	Consultant Critical Care & Emergency Medicine	Frimley Park Hospital Foundation Trust
11	Medical – Long Term Conditions and Acute Medicine	Peter Hockey	Clinical Director	Southern Health NHS Foundation Trust
			Deputy Post-graduate Dean	Health Education England (Wessex)
12	Public Health	Mohit Sharma	Consultant in Public Health	Public Health England
13	Clinical Governance	Angela Anderson	Clinical Governance and Quality Lead, Children's Services	Solent NHS Trust
14	Nursing	Becky Hepworth	Community Children's Nurse Team Leader	Isle of Wight NHS Trust
15	Ambulance Service	David Partlow	Clinical Development Manager	South Western Ambulance Service
16	Operational Management	Duncan Lining-Carp	Manager, Southampton Children's Hospital	University Hospitals

APPENDIX C – List of Senate Council Members at July 2015 and May 2016 (please note: not all members participated in the process due to potential conflict of interest)

	Name	Role	Employing Organisation (at that time)
1	Professor William Roche	Chair	NHS England South (Wessex)/Southampton University
2	Michael Baker	Member	Public Health England
3	Dr Lionel Cartwright	Member	The Harvey Practice, Broadstone/Dorset CCG
4	Dr Gary Connett	Member	University Hospitals Southampton/Southampton University/Wessex Deanery
5	Dr Denise Cope	Member & Clinical Network Director (Mental Health)	Dorset Healthcare University NHS Foundation Trust/Health Education England (Wessex)/NHS England South (Wessex)
6	Suzanne Cunningham	Member	University Hospital, Southampton/Bournemouth University
7	Dominic Hardy	Member	NHS England South (Wessex)
8	Fiona Haughey	Member	Dorset HealthCare University NHS Foundation Trust
9	Mr Matthew Hayes	Member and Clinical Network Director (Cancer)	University Hospital, Southampton
10	Dr Adrian Higgins	Member	West Hampshire CCG/Southbourne Surgery
11	Dr Richard Jones	Member and Clinical Network Director (Diabetes)	Portsmouth Hospitals NHS Trust/NHS England South (Wessex)

	Name	Role	Employing Organisation (at that time)
12	Dr Chris Kipps	Member and Clinical Network Director (Diabetes)	University Hospital, Southampton
13	Dr Hayden Kirk	Member	Solent NHS Trust
14	Dr Ranjit Mahanta	Member	Surrey & Borders Partnership NHS Foundation Trust
15	Dr Daniel Meron	Member	Solent NHS Trust
16	Dr Liz Mearns	Member	NHS England South (Wessex)
17	Dr Andrew Mortimore/Dr Bob Coates	Member	Southampton City Council
18	Dr Alyson O'Donnell	Member and Clinical Network Director (Maternity, Children and Young People)	University Hospital, Southampton/NHS England South (Wessex)
19	Dr Simon Plint	Member	Health Education England (Wessex)
20	Frank Rust	Member	Rushmoor Borough Council
21	Dr Mohit Sharma	Member	Public Health England
22	Sally Shead	Member	Dorset CCG
23	Cathy Stone	Member	Portsmouth Hospitals NHS Trust
24	Dr Nigel Watson	Member	Arnewood Practice/Wessex Local Medical Committees
25	Ruth Williams	Member	NHS England South (Wessex)

APPENDIX D

Senate Support Team

	Role	Name	Title	Organisation
1	Support	Sara Cobby	Senate Support Officer	NHS England South (Wessex)
2		Samantha Cosserat	Quality Improvement Lead	
3		Debbie Kennedy	Senate Manager	
4		Lucy Sutton	Associate Director Clinical Network and Senate	

APPENDIX E – Terms of Reference for First and Second Review

CLINICAL REVIEW: TERMS OF REFERENCE

Title: Dorset Clinical Services

Sponsoring organisations: Dorset CCG

Clinical Senate: Wessex

NHS England regional or area team: Wessex

Terms of reference agreed by:

Name	Professor William Roche
on behalf of	Wessex Clinical Senate
Signature	
Date:	25.03.2015

Name	Tim Goodson
on behalf of sponsoring organisation	Dorset CCG
Signature	
Date	**13/03/15**

Name	Liz Mearns, Medical Director
on behalf of sponsoring organisation	Wessex Area Team
Signature	
Date:	23/3/15

1. Clinical review team members

The Clinical Senate Chair and Manager will recruit an independent clinical review team consisting of:

a. Chair or lead member (appointed by clinical senate council chair)
b. Patient / citizen representatives
c. Commissioners: CCGs, NHS England Area Team
d. Providers: primary, secondary, community, mental health, social care, other e.g. Ambulance trust
e. Clinical experts to be determined following receipt of the first draft pre-consultation business case by the Senate Manager and may include clinicians from the following specialties: maternity, paediatrics, planned and specialist care, urgent and emergency care, people with long term conditions and frail elderly)
f. Public Health

It is expected that a team of between 10 and 20 individuals will undertake the review. In order to ensure that appropriate team members are recruited, Dorset CCG will share the First Draft Pre-Consultation Business Case by **Thursday 19th March 2015** at the latest. This document will be confidential and viewed only by the Senate Team who will not disclose its contents.

2. Aims and objectives of the clinical review

The Senate Review Team will abide by the draft national guidance entitled "Clinical Senate review process guidance notes" which was agreed by NHS England on 16 July 2014. This document provides guidance about the role of Clinical Senates in providing clinical advice to inform NHS England's service change assurance process. The terms of reference template in this document has been used to draft this paper.

Clinical Senate
Review Process - Aug

Wessex Clinical Senate has been asked by Dorset CCG to provide clinical advice on the service change proposal formulated by themselves in partnership with

McKinsey's to develop new services in Dorset which better meet the population's needs. This is part of the formal NHS England service change assurance process which sets out the approach as below.

3. Scope of the review

NHS England has a role to support and assure the development of proposals and the case for change by commissioners. The principles of the assurance are that it should be robust, consistent and supportive. At the heart of the NHS England assurance process for service change are the four tests from the Government's Mandate to NHS England[1].

The four tests, intended to apply in all cases of major NHS service change during normal stable operations, are:

i. Strong public and patient engagement;
ii. Consistency with current and prospective need for patient choice;
iii. A clear clinical evidence base; and
iv. Support for proposals from clinical commissioners.

In addition to these four tests, the NHS England assurance toolkit[2] also identifies a range of best practice checks for service change proposals, these include:

i. Clear articulation of patient and quality benefits;
ii. The clinical case fits with national best practice; and
iii. An options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.

The team will review the service change proposals against the appropriate key test (clinical evidence base) and the best practice checks that relate to clinical quality.

The Clinical Senate Council will be asked to consider the review team's findings and comment specifically on:

[1] Planning and delivering service changes for patients, NHS England December 2013 http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

[2] Effective Service Change: a support and guidance toolkit, NHS England, awaiting publication

i. The comprehensiveness and applicability of the review.
ii. The content and clarity of the review and its suitability to the population in question.
iii. The interpretation of the evidence available to support its recommendations.
iv. The likely impact on patient groups affected by the guidance.
v. The likely impact / ability of the health service to implement the recommendations.

4. Timeline

Ideally the request for advice should be received at least three months in advance of the anticipated clinical review start date. In this case the full business case and background information should be received no later than **Friday 15th May 2015** by the Senate Manager.

It is recognised by Dorset CCG that the Senate Council aims to issue the final report in the week beginning **3rd August 2015**. The Wessex Clinical Senate Manager has strongly advised the CCG include in its risk register steps to mitigate any impact on the delivery of services if the milestones in Appendix A are not realised due to unforeseen circumstances and this becomes an issue. Participation in the review team is entirely voluntary and this may constrain the Senate's ability to deliver to the agreed timescales.

Other points to note are that the Wessex Clinical Senate has been asked to conduct the clinical review using a new national process which is new and under continuing review.

However, the Wessex Clinical Senate recognises that Dorset CCG has been working on the clinical case for change for some time. We will therefore aim to deliver at the very least a first draft outline of the report for fact checking to Dorset CCG by **17th July 2015.**

Our aim in drafting the following timeline is for an interactive process which does the work which has been produced so far justice in a short timescale. We should be able to give the clinical members of our review team the required minimum of six weeks' notice.

There are some milestones which need to be met by Dorset CCG in order to achieve the critical path for the issue of final advice in the week beginning. Appendix A shows these shared milestones chronologically and colour coded by organisation. A green box indicates CCG's responsibilities; a yellow box indicates Senate responsibilities. All critical path milestones are in red type.

It is also recognised by all parties that there is no contingency time allowed for in this timeline.

Key Milestones in the delivery of this report are as follows:

Terms of Reference signed by CCG & returned by 13th March 2015.

First draft pre-consultation business case sent to Senate Manager by the CCG by 19th March 2015. This is needed because it will assist with the recruitment of the review team.

Review Team recruited before 3rd April 2015

3rd – 15th June 2015: Review underway

Week beginning 10th June 2015 – visits to providers/sites to be arranged.

18th June 2015 – Draft Review Team report sent to CCG for fact checking

25th June 2015 – Responses sent back by CCG

29th June 2015 - Draft report and agenda sent out for Clinical Senate Council meeting on 8th July 2015 (N.B. 7 days to read agenda instead of 21 as normal)

8th July 2015: Senate Council Meeting (N.B. Full day). We will need CCG/providers to present their case.

17th July 2015 – Senate Council Draft Assurance Report shared with the clinical review team/Dorset CCG for fact-checking.

26th July 2015 – Responses to the draft report received by Senate Manager from the sponsoring organisations in writing.

3rd August 2015 – Final Report sent to CCG and NHS England

5. Reporting arrangements

The national document states that "the Clinical Review Team will draft a report and, prior to submission to clinical senate council for its consideration, the team may wish to provide a copy to the sponsoring organisation for factual accuracy checking purposes only (this will be built into the timeline)".

If there is a recommendation from the Senate Council that the plans are clinically robust then they will advise NHS England that the CCG is ready to proceed to consultation. The Senate Council only considers the clinical case, so they cannot make the final decision on consultation. The Senate Council's final report will be published simultaneously with the launch of the CCG consultation process.

6. Methodology

The CCGs will supply the full business case and background information. Details of background information required are provided later in these terms of reference.

The Chair and Senate Manager will review the information submitted and make it available to the Clinical Review Team to assist with answers to any questions on the clinical case.

The Chair and Senate Manager will submit any questions posed by the Clinical Review Team which cannot be answered by the clinical case or the background information to the CCGs for a response during the review weeks of 3rd – 15th June 2015 at these will be answered by e-mail at the latest by the final review team meeting on 16th June 2015.

It is crucial that all responses from CCGs are received by the Senate Manager before that date or there will be an impact on the timeline.

The leads from each organisation who will confirm the questions and answers in writing/by e-mail are:

Wessex Clinical Senate:

Debbie Kennedy

Senate Manager

NHS England (Wessex)

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Address: NHS Dorset CCG, Vespasian House, Barrack Road, Dorchester, DT1 1TG
Telephone No. 01305 213605 Mobile: 07833 435651
Email: faye.brooks@dorsetccg.nhs.uk

Name: Katherine Gough
Address: NHS Dorset CCG, Vespasian House, Barrack Road, Dorchester, DT1 1TG
Role: Quality lead CSR/Chief Pharmacist
Telephone No. 01305 213610
Email: Katherine.gough@dorsetccg.nhs.uk

Dorset Health and Wellbeing Board:

DORSET HEALTH AND WELLBEING BOARD
Ann Harris, Health Partnerships Officer: 01305 224388 a.p.harris@dorsetcc.gov.uk

BOURNEMOUTH AND POOLE HEALTH AND WELLBEING BOARD
Matthew Wisdom, Democratic and Overview & Scrutiny Officer, Legal and Democratic.
Tel: 01202 451107. E-Mail: matthew.wisdom@bournemouth.gov.uk
Or
Debra Jones. Email: debra.jones@bournemouth.gov.uk

7. Report

A final Clinical Senate assurance report will be made to the sponsoring organisations for fact checking prior to publication on 17th July 2015.

Comments/ correction must be received within 5 working days so that the report can be published on 3rd August 2015 or when the CCG launches its consultation.

8. Communication and media handling

As part of the transparency of the whole assurance process the CCGs will publish the consultation stating their consideration of the Wessex Senate recommendations. The consultation will include a link to the Wessex Senate website for the full Senate report which will be published simultaneously with the CCG consultation process.

A communications plan, which describes how the advice will be shared further and with whom, will be finalised by 3rd August 2015.

The following organisations will work in partnership on the communications plan

NHS England:

Details to be supplied

Dorset CCG:

Kirsty Campbell

Communications Lead

NHS Dorset Clinical Commissioning Group

Vespasian House

Barrack Road

Dorchester

DT1 1TG

Tel: 01305 368058 / Mobile: 07768486576

Dorset Health and Wellbeing Board:

Not applicable refer to the CCG

9. Resources

The NHS England Area Team will provide administrative support to the 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 organisations.

10. Accountability and Governance

The Wessex Clinical Senate has an accountability and governance structure, which describes the responsibilities of the Clinical Senate. Members of the Senate Council abide by a conflict of interest policy.

The Wessex Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisations.

The sponsoring organisations remain accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisations may wish to fully consider and address before progressing their proposals/preferred option.

11. Functions, responsibilities and roles

The **sponsoring organisations** will

i. Provide the Clinical Senate Manager with a first draft pre-consultation business case which will assist with the recruitment of the external clinical review team.

ii. Provide the external clinical review team with a full business case which includes the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. 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, modelling of rotas across and within organisations, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisations will provide any other additional background information requested by the external clinical review team.

iii. Respond within the agreed timescale to the draft and final reports on matter of factual inaccuracy.

iv. Undertake not to attempt to unduly influence any members of the external clinical review team during the review.

v. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisations will

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

Clinical Senate council will

vi. Appoint an external 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.

vii. Endorse the terms of reference, timetable and methodology for the review

viii. Consider the review recommendations and report (and may wish to make further recommendations)

ix. Request suitable support for the team and

x. Submit the final report to the sponsoring organisations

External clinical review team will

xi. Undertake its review in line the methodology agreed in the terms of reference

xii. Follow the report template and provide the sponsoring organisations with a draft report to check for factual inaccuracies.

xiii. 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.

xiv. Keep accurate notes of meetings.

External clinical review team members will undertake to

xv. Commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).

xvi. Contribute fully to the process and review report

xvii. Ensure that the report accurately represents the consensus of opinion of the external clinical review team

xviii. Comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the external 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

NHS
Dorset
Clinical Commissioning Group

Vespasian House
Barrack Road
Dorchester
Dorset
DT1 1TG

Tel: 01305 368900
Fax: 01305 368947
www.dorsetccg.nhs.uk

13 March 2015

Debbie Kennedy

Senate Manager
NHS England (Wessex)
Oakley Road
Southampton
SO16 4GX

Dear Debbie,

Re: Clinical Senate Review: Dorset Clinical Services Review

Thank you for your help in starting the clinical senate review process for Dorset CCG. Please find enclosed the signed copy of the Terms of Reference as per my email of 13th March 2015.

I have also enclosed some copies of the need for change document. The supporting documents can also be found at http://www.dorsetsvision.nhs.uk/need-to-change/

Please let me know what further information you need, and we will send you a copy of the draft PCBC for restricted viewing on 19th of March as per the milestones document.

Yours sincerely

Katherine Gough
Head of Medicines Management/CSR Quality and Assurance lead

CLINICAL REVIEW: TERMS OF REFERENCE

Title: Dorset Clinical Services

Sponsoring organisations: Dorset CCG & Dorset Health and Wellbeing Board

Clinical Senate: Wessex

NHS England regional or area team: Wessex

Terms of reference agreed by:

Name	Professor William Roche, Chair
on behalf of	Wessex Clinical Senate
Signature	
Date:	04/05/2016

Name	Tim Goodson, Chief Officer
on behalf of sponsoring organisation	Dorset CCG
Signature	
Date	29/04/2016

Name	Liz Mearns, Medical Director
on behalf of sponsoring organisation	NHS England South (Wessex)
Signature	
Date:	04/05/2016

1. Clinical review team members

The Clinical Senate Chair and Manager will reconvene the former clinical review team. It may be necessary to supplement the team with new members where the original members are unavailable or have left employment.

It is expected that a team of 20+ individuals will undertake the review. The review will focus on securing answers to the questions asked in the Senate Council report dated 8th July 2015.

Dorset CCG has indicated that they will make available some documentation from **4th May 2016.** The external review team need at least two weeks to read the papers but an absolute minimum of one week. So **9th May 2016** is the cut of date for receipt of papers. Papers received after that date cannot be considered. In order that the Senate Council report is ready for the Stage 2 Assurance Meeting on **8th June 2016**, normal timescales have been condensed from three months to less than one month.

The documents will be confidential and viewed only by the Senate and External Review Team who will not disclose the contents.

2. Aims and objectives of the clinical review

The Senate Review Team will abide by the draft national guidance entitled "Clinical Senate review process guidance notes" which was agreed by NHS England on 16 July 2014. This document provides guidance about the role of Clinical Senates in providing clinical advice to inform NHS England's service change assurance process. The terms of reference template in this document has been used to draft this paper.

Clinical Senate
Review Process - Auc

NHS England published guidance designed to be used by those considering, and involved in, service reconfiguration to navigate a clear path from inception to implementation. It supports commissioners to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.

In addition, it sets out how new proposals for service change or reconfiguration are tested through independent review and assurance by NHS England.

This document replaces 'Planning and delivering service change', published by NHS England in December 2013. Clinical Commissioning Groups (CCGs) are under a statutory duty to have regard to this guidance[1].

3. Scope of the review

NHS England has a role to support and assure the development of proposals and the case for change by commissioners. The principles of the assurance are that it should be robust, consistent and supportive. At the heart of the NHS England assurance process for service change are the four tests from the Government's Mandate to NHS England.

The four tests, intended to apply in all cases of major NHS service change during normal stable operations, are:

i. Strong public and patient engagement;
ii. Consistency with current and prospective need for patient choice;
iii. A clear clinical evidence base; and
iv. Support for proposals from clinical commissioners.

In addition to these four tests, the guidance identifies a number of best practice checks for service change proposals (see Annex 3), these include:

i. Clear articulation of patient and quality benefits;
ii. The clinical case fits with national best practice; and
iii. An options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.

The team will review the service change proposals against the appropriate key test (clinical evidence base) and the best practice checks that relate to clinical quality.

[1] Planning, assuring and delivering service change for patients, NHS England 1st November 2015 https://www.england.nhs.uk/resources/resources-for-ccgs/#service-change

The Clinical Senate Council will be asked to consider the review team's findings and comment specifically on:

i. The comprehensiveness and applicability of the review.
ii. The content and clarity of the review and its suitability to the population in question.
iii. The interpretation of the evidence available to support its recommendations.
iv. The likely impact on patient groups affected by the guidance.
v. The likely impact / ability of the health service to implement the recommendations.

4. Timeline

Ideally the request for advice should be received at least three months in advance of the anticipated clinical review start date. In usual circumstances if the full business case and background information would be received on **4th May 2016** by the Senate Manager and the Senate Council would issue the final report on or around **3rd August 2016.**

NHS England and Dorset CCG have requested the Senate Council report on or around the **1st June 2016.**

The Wessex Clinical Senate Manager has strongly advised the CCG include in its risk register steps to mitigate any impact on the delivery of services if this milestone is not realised due to unforeseen circumstances and this becomes an issue.

Participation in the review team is largely voluntary and this may constrain the Senate's ability to deliver to the agreed timescales.

The Wessex Clinical Senate recognises that Dorset CCG has been working on the clinical case for change for some time and that most of the members of the external review team are the same as before.

The former external review team members were only available to meet on 17th May 2016. Their report will be discussed by the Senate Council on 24th May 2016. ***There is therefore no time to receive feedback from the external review team***

members and Dorset CCG before papers are sent out for the Senate Council meeting.

We will aim to deliver at the very least a draft outline of the report for fact checking to Dorset CCG by midnight on **Friday 27th May 2016.**

Key Milestones in the delivery of this report are as follows:

1. Terms of Reference signed by CCG & returned by **4th May 2016.**
2. All documentation to be sent to Senate Manager by **4th May 2016.**
3. All documentation to be reviewed by the Senate Chair and Senate Manager **4th – 9th May 2016.**
4. All relevant documentation sent to external review team members by **10th May 2016.** Conflict of interest declarations and confidentiality agreements returned and signed before documentation sent out.
5. Pre-meetings between Senate Manager and new review team members on **10th** and **11th May 2016.**
6. Formal external review team meeting all day **17th May 2016.**
7. The report of the review team will be drafted and sent to external review team members for comment at the same time as it is sent to Senate Council members by midnight on **19th May 2016.**
8. Senate Council meeting to receive the external review team report will be held on **24th May 2016**. Dorset CCG invited to attend.
9. Report sent to Dorset CCG for fact checking on **27th May 2016.**
10. Final report sent to NHS England and Dorset CCG on **1st June 2016.**

These milestones are summarised in Appendix A at the end of this document.

5. Reporting arrangements

The national document states that "the Clinical Review Team will draft a report and, prior to submission to clinical senate council for its consideration, the team may wish to provide a copy to the sponsoring organisation for factual accuracy checking purposes only (this will be built into the timeline)".

If there is a recommendation from the Senate Council that the plans are clinically robust then they will advise NHS England that the CCG is ready to proceed to

consultation. The Senate Council only considers the clinical case, so they cannot make the final decision on consultation. The Senate Council's final report will be published simultaneously with the launch of the CCG consultation process.

6. Methodology

The CCGs will supply the full business case and background information. Details of background information required are provided later in these terms of reference. The details of information required are the same as in the terms of reference for the first review.

The Senate Council provided the CCG with its 8th July 2015 report on the first review on 30th July 2015. Dorset CCG has been compiling information to address the recommendations in this report since that date. The CCG provided two draft responses which were shared with Senate Council members via e-mail on 22nd February 2016 and 6th April 2016 and discussed at subsequent informal meetings.

The Chair and Senate Manager will review the information submitted between **4th – 9th May 2016** and make it available to the Clinical Review Team to assist with answers to any questions on the clinical case.

The CCG will make available the following clinical leads and commissioning managers at specified hour long slots between on **5th, 6th and 9th May 2016** to answer any questions that the Chair and Senate Manager may have and to supply further information if necessary. **Any evidence supplied after 9th May 2016 cannot be considered by the external review team or Senate Council.**

The leads from the CCG who will answer questions and make available further information on request will be supplied by the CCG by 4th May 2016 and attached as Appendix B to this document.

All contact with the Wessex Clinical Senate should be via:

Debbie Kennedy
Senate Manager
NHS England (Wessex)
Oakley Road
Southampton

SO16 4GX
Tel: 01138249829
Email: debbie.kennedy1@nhs.net

7. Report

A final Clinical Senate assurance report will be made to the sponsoring organisations for fact checking prior to publication on **27th May 2016**.

Comments/ correction must be received within 1 working day so that the report can be finalised by **1st June 2016.**

8. Communication and media handling

As part of the transparency of the whole assurance process the CCGs will publish the consultation stating their consideration of the Wessex Senate recommendations. The consultation will include a link to the Wessex Senate website for the full Senate report which will be published simultaneously with the CCG consultation process.

A communications plan, which describes how the advice will be shared further and with whom, will be finalised by **8th June 2016.**

The following organisations will work in partnership on the communications plan

NHS England:

Carol Wood
Head of Communications and Engagement
NHS England South (Wessex)
Oakley Road | Southampton | SO16 4GX

0113 8252994
07814229000
www.england.nhs.uk
carol.wood4@nhs.net
For urgent out of hours issues contact - Pager: 0844 822 2888 (Quote SCOMM01 with your message)

Dorset CCG:

Jackie Green
Interim Head of Communications

NHS Dorset Clinical Commissioning Group
Canford House
Discovery Court Business Centre
551-553 Wallisdown Road
Poole
BH12 5AG
communications@dorsetccg.nhs.uk
Communications and Engagement Team

Tel: 01202 541 946 Answerphone and email checked daily.

Bournemouth & Poole Health and Wellbeing Board and Dorset Health and Wellbeing Board: please contact through Dorset CCG Communications as there has been a joint communications strategy for the Dorset CSR

9. Resources

The NHS England Area Team will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

Dorset CCG will pay for venues and review team time where necessary (most team members have been released from their employing organisation but some are self-employed and require payment). At present this is estimated at £6,000.

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

10. Accountability and Governance

The Wessex Clinical Senate has an accountability and governance structure, which describes the responsibilities of the Clinical Senate. Members of the Senate Council abide by a conflict of interest policy.

The Wessex Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisations.

The sponsoring organisations remain accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisations may wish to fully consider and address before progressing their proposals/preferred option.

11. Functions, responsibilities and roles

The **sponsoring organisations** will

i. Provide the Clinical Senate Manager with a response to the Senate Council recommendations and a pre-consultation business case plus any other information which the Chair and Senate Manager requests by **4th May 2016**.

ii. Provide the external clinical review team with a full business case which includes the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. 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, modelling of rotas across and within organisations, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Five Year Forward View, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisations will provide any other additional background information requested by the Senate Chair and Manager by **9th May 2016**.

iii. Respond within the agreed timescale to the External Review Team/Senate Council reports on matters of factual inaccuracy.

iv. Undertake not to attempt to unduly influence any members of the external clinical review team during the review.

v. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisations will

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

Clinical Senate council will

vi. Re-convene the former external 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.

vii. Endorse the terms of reference, timetable and methodology for the review

viii. Consider the review recommendations and report (and may wish to make further recommendations)

ix. Request suitable support for the team and

x. Submit the final report to the sponsoring organisations

External clinical review team will

xi. Undertake its review in line the methodology agreed in the terms of reference

xii. Follow the report template and provide the sponsoring organisations with a draft report to check for factual inaccuracies.

xiii. 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.

xiv. Keep accurate notes of meetings.

External clinical review team members will undertake to

xv. Commit fully to the review and attend all briefings and meetings that are part of the review (as defined in methodology).

xvi. Contribute fully to the process and review report.

xvii. Ensure that the report accurately represents the consensus of opinion of the external clinical review team.

xviii. Comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the external 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 A

Summary of SHARED MILESTONES				
18th April	19th April	20th April	21st April	22nd April
25th April	26th April	27th April	28th April	29th April
2nd May	3rd May	4th May	5th May	6th May
		Signed Terms of Reference for review received	DK to request any additional documentation needed from Clinical Leads/Commissioning Managers See appendix 1 for contacts.	
		CCG to send response to Senate Council recommendations and PCBC to DK		
9th May	10th May	11th May	12th May	13th May
DK to request any additional documentation needed from Clinical Leads/ Commissioning Managers	All conflict of interest and confidentiality agreements received	Pre-meeting with new external review team members		
	Pre-meeting with new external review team members			
	DK to send agenda out to review team members			
16th May	17th May	18th May	19th May	20th May
	External review team to discuss documentation received from CCG	Governing Body to discuss final pre-consultation business case	DK to send out draft report to external review team members for fact-checking and Senate Council members	
23rd May	24th May	25th May	26th May	27th May
	Senate Council Meeting			DK to send final report to CCG for fact-checking
30th May	31st May	1st June	2nd June	3rd June
Bank Holiday	CCG to return final report to DK after fact-checking	Final report sent to NHS England and CCG		
6th June	7th June	8th June	7th June	8th June
		Stage 2 Assurance Meeting		

Key to colour-coding	Pink boxes = Senate activities
	Yellow boxes = Joint activities
	Green boxes = CCG activities
	Red font = critical path/milestones which will delay report if not met.