NHS
West Midlands
Clinical Senate

West Midlands Clinical Senate

The Future of Local Health Services in Northern Staffordshire

Stage 2 Clinical Assurance Review Panel Final Report

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Stage 2 Clinical Assurance Review Panel Final Report

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The statement above will require contact details adding and should not be altered to any less than 16 point and for longer documents it would be appropriate to duplicate the statement on the back cover. *Please remember to delete this sentence from your final version.*

West Midlands Clinical Senate

Contents

1. Panel Chair / Clinical Senate Chair Foreword

The Clinical Senate Council was asked by North Staffordshire CCG and Stoke CCG to provide independent clinical advice on the proposed Future of Local Health Services in Northern Staffordshire reconfiguration with specific reference to community beds. At the time of the review the preferred option had not been determined as an options appraisal process was still underway. The panel therefore made the comments and recommendations in this report in the context of the emerging sense of direction. An additional half day discussion with panel members has been scheduled to review the preferred option which has now been shared following conclusion of the relevant stages of the option appraisal. The conclusions and further reflections of the panel with reference to the preferred option will be provided shortly as a separate document which can be appended to this report in due course.

A multi-disciplinary panel sat for 2 days, one of which included a series of very helpful site visits to the main community hospital sites so that the panel could review and assess the options proposed.

The panel considered national best practice and was confident that the direction of travel was in line with the national policy direction around integrated care in community settings. The panel recognised that the current situation involving extended temporary closures needed to be concluded as the current situation is not in anyone's best interests. It was however recognised that the interim position did provide a clear opportunity to review the evidence base on the impact of the temporary changes in bed configuration on the local model of care and alternative pathways for patients.

The panel recognised that the timing of this process and the STP conversations was not ideal but the panel was confident that the high level proposals were consistent with the STP Strategic direction and plans. There were however some risks identified related to system wide engagement which still need to be refined to ensure there is enough flexibility in the system to respond to fluctuations in demand.

We recognise that decisions of this nature are always difficult and we support the ongoing commitment of the CCGs to continue to engage local people and patients in this change process.

Sarah Dugan

1.1 Advice Request

The West Midlands Clinical Senate was asked by North Staffordshire CCG and Stoke-on-Trent CCG to provide independent clinical advice on the proposed Future of Local Health Services in Northern Staffordshire re-configuration with specific reference to community beds.

The request was made in February 2018 and clarification of the scope of the request was developed during April and May 2018.

The West Midlands Clinical Senate was asked to review the documentation, evidence and answer the following questions:

a) Does the Senate support the proposed clinical model related to the community bed configuration and the hub approach with specific reference to quality, safety and clinical sustainability?
b) Is the proposed number of community beds adequate?
c) Is the commissioned amount of alternative services (e.g. Home First / D2A) adequate?

The scope of the advice requested did not include reviewing the preferred options for the specific configuration of community care beds as these were still being developed at the time of the review. The CCG also confirmed on Day One of the review that the prevention/ public health offer and voluntary and community sector was out of scope for this review.

The evidence and information provided for the clinical review panel was provided by North Staffordshire CCG and Stoke-on-Trent CCG.

(NB. The **background** for the review is detailed in **Section 4** of the report).

2. Methodology and Governance

2.1 Terms of Reference

2.1.1 North Staffordshire CCG and Stoke-on-Trent CCG - Future of Local Health services in Northern Staffordshire was formally adopted onto the Clinical Senate work programme by the Clinical Senate Council in January 2018, following a presentation to the council and request for NHS England Stage II Clinical Assurance. The Independent Clinical Review Team (ICRT) Chair and Vice Chair were appointed by the council. A request to the West Midlands Clinical Senate from North Staffordshire CCG and Stoke-on-Trent CCG for NHS England Stage II Clinical Assurance was formally received on 20th February 2018.

2.1.2 Terms of reference (TOR) for the Council's work were developed as per NHS England guidance (See Appendix 1). This included the approach for formulating the advice and the overall process through which advice and recommendations would be developed. Discussions took place from April 2018 to May 2018 between the Clinical Senate, and North Staffordshire CCG and Stoke-on-Trent CCG to shape and agree the TOR. The TOR for the review were signed off by Zara Jones, Director of Strategy, Planning and Performance North Staffordshire CCG and Stoke-on-Trent CCG and Sarah Dugan, Clinical Senate Council Member and Chair of the Review.

2.2 Process

2.2.1 The process to formulate the advice was led by Sarah Dugan and Professor Guy Daly, the process was guided by the Clinical Senate Review Process Guidance Notes (2014).

2.2.2 The Clinical Senate formulated advice in May 2018. An Independent Clinical Review Team (ICRT) was established to assist the Senate. This included members from professional groups with specific knowledge and expertise in the areas which the Clinical Senate had been asked to provide advice. To ensure any advice given was robust, transparent and credible; the team included clinical experts from across the West Midlands area (See Table 1) and (Appendix 1& 2). A Confidentiality agreement and potential conflicts and associations were declared during the process. (These are recorded in Appendix 1&2)

2.2.3 Review dates were held on 8th May and 21st May 2018 (See Appendix 3-4). The ICRT review documentation was provided by North Staffordshire CCG and Stoke-on-Trent CCG (See Appendix 5).

2.2.4 Presentations relevant to the review were made from key members from North Staffordshire CCG and Stoke-on-Trent CCG.

2.2.5 The first day of the review consisted of a site visit to the five hospital sites under review:

- Bradwell Hospital
- Haywood Hospital
- Longton Cottage Hospital
- Leek Moorlands Hospital
- Cheadle Hospital

2.2.6 The senate requested that a site visit should be carried out to inform discussions on the development of the TOR. Eight members of the panel undertook the site visit on 8th May. The panel members met with the staff members currently delivering care from the some of the estate sites.

2.2.7 At the end of Day One further information was requested from North Staffordshire CCG and Stoke-on-Trent CCG to provide more clarity on the clinical model(s), this was to be provided on Day Two. It was established through the CCG's that a preferred clinical model would not be available for day two of the clinical senate review, but a long list of options would be available with a steer on possible viable options (North Staffordshire CCG and Stoke-on-Trent CCG A 2018).

2.2.8 Following Day One the TOR was refined and signed off by the CCG's and the Clinical Senate.

2.2.9 Day Two provided an opportunity for further evidences and presentations to be made by North Staffordshire CCG and Stoke-on-Trent CCG, in relation to the questions as per TOR.

2.2.10 At the close of Day Two the panel requested that a summary report should be written of the panel's clinical opinion of the evidence presented to date. A further date was scheduled Day Three to give a clinical senate opinion on the proposed North Staffordshire CCG and Stoke-on-Trent CCG preferred model for the Future of Local Health Services in Northern Staffordshire. A provisional date July 20th was made pending readiness of the CCG to present their preferred model.

2.2.11 This report presents the key issues that were discussed and the clinical opinion formed on the proposed Future of Local Health Services in Northern Staffordshire from the evidence presented (documentary and verbally). It is not intended to be a comprehensive record of the discussion.

2.3 Scope and Limitations

2.1.3 The scope of the review was agreed between North Staffordshire CCG and Stoke-on-Trent CCG and the West Midlands Clinical Senate as per TOR. The conclusions are limited to the evidence presented, and are not exhaustive.

Table 1 – Independent Clinical Review Team Members

Chair:

Name	Position	Organisation
Sarah Dugan Panel Chair	Chief Executive Chief Executive lead	Worcestershire Health and Care NHS Trust Herefordshire and Worcestershire STP

Members:

Name	Position	Organisation
Andrea Westlake	Assistant Head of Nursing and Quality	NHS England – West Midlands
Professor Guy Daly	Pro Vice-Chancellor (Health and Life Sciences)	Coventry University
Paul Maubach	Chief Executive	Dudley Clinical Commissioning Group
Paula Furnival	Executive Director for Adult Social Care	Walsall Council
Dr Simon Harlin	GP Medical Lead, Rapid Response Team	Walsall Healthcare NHS Trust
Dr Shyam Menon	Consultant Gastroenterologist and	The Royal Wolverhampton NHS Trust

	Clinical Director for Gastroenterology	
Nighat Hussain	Programme Director, West Midlands Integrated Urgent Care, Transformation Directorate	Sandwell and West Birmingham CCG
Melvena Anderson	General Manager, Planned Care (Social Work and Mental Health)	Black Country Partnership NHS Foundation Trust
Linzie Bassett	Clinical Team Lead for Stroke and neuro therapies	Birmingham Heartlands and Solihull Hospitals
Jonathan Hopkins	Consultant Radiologist Head of School of Radiology RCR Regional Chair	University Hospitals Birmingham HEE (West Midlands) West Midlands; Royal College of Radiologists
Brendan Young	Patient Representative	N/A
In attendance		
Angela Knight Jackson	Head of Clinical Senate	West Midlands CN and Senate NHS England
Katy Wheeler	Clinical Senate Administrator	West Midlands CN and Senate NHS England

3. Background

(Extract adapted from North Staffordshire CCG and Stoke-on-Trent CCG PID (2018) and The Case for Change North Staffordshire CCG and Stoke-on-Trent CCG).

3.1.1 The NHS England Five Year Forward View (2014) describes new models of care which support local health economies to integrate community services and shift care into homes and community settings.

3.1.2 The "Next Steps on the NHS Five Year Forward View (5YFV)" was published on 31 March 2017. This plan explains how the 5YFV's goals will be implemented over the next two years. Urgent and Emergency Care (UEC) is one of the NHS's main national service improvement priorities, with focus on improving national A&E performance whilst making access to services clearer for patients with the aim to improve the urgent and emergency care system so patients get the right care in the right place, whenever they need it.

3.1.3 A report by the Independent Commission on Improving Urgent Care for Older People states that excellent care supports medical and non-medical care in the most appropriate setting (NHS Confederation2016). This means patients only being admitted to hospital if they need treatment that cannot safely be provided in the community.

4. National Standards

The Future of Local Health services in Northern Staffordshire are in line with national policy direction as set out by the Five Year Forward View (2014) and Next Steps Five Year Forward View (2017).

National evidence cited by North Staffordshire CCG and Stoke-on-Trent CCG to support the service reconfiguration include:

Local Government Association – High Impact Change model (2017)
ECIP evidence (2016)

National Audit Office – Discharging Older people from Hospital (2016)

NHS Confederation, Growing Old Together – Sharing New Ways to Support Older People, (2016)

Monitor, Moving healthcare closer to home: Literature review of clinical impacts, (2015)

Public Accounts committee (2015)– Discharging People from Acute Hospitals
King's Fund response to the PAC report on discharging older people from hospitals (2015)

House of Commons Health Committee, Managing the Care of People with Long-term Conditions, second report of session 2014-15,(2014)

NHS England, High quality care for all, now and for future generations: Transforming urgent and emergency care services in England – Urgent and Emergency Care Review End of Phase 1 Report, 2013

Kings Fund – Continuity of Care for Older Hospital Patients March 2012
Age and Ageing, BGS (2011)

www.mintel.com/press-centre/social-and-lifestyle/dementia-is-the-leading-age-concern-for-brits-aged-55

www.dementiasupport.ca/web/alzheimers-disease-and-dementia/dementia-myths

www.alzheimers.org.uk/info/20027/news_and_media/541/facts_for_the_media

Hazards of hospitalization of the elderly Ann Intern med 1993;118(3)219-23

4.1 Context

(Extract adapted from The Case for Change North Staffordshire CCG and Stoke-on-Trent CCG)

4.1.1 Nationally, there is a drive towards better integrated services, with more being delivered in a patient's own home or local community and there is evidence that for some health conditions this can provide good bed based care. This should be in combination with an offer of better opportunities for prevention and self-care to support people to live healthier lives which will in turn improve patient outcomes, address health inequalities and reduce demand on the system. Support for people in managing their conditions and preventing ill health is needed and providing suitable care will mean that primary care and hospitals need to change how they deliver care such as providing more proactive services in the community and spending proportionately more on those services in local communities. The evidence suggests a need to think differently and develop and deliver quality services fit for current and future population.

4.1.2 The health and social care needs of the population of the North Staffordshire and Stoke on Trent are changing. People are living longer and have different conditions and health needs: there are increasing numbers of people diagnosed with dementia, and more and more people have long-term health conditions that require ongoing support and management. Bedded hospital care will not provide an appropriate solution to address the above problems. A future model is needed that is less reliant on bedded care and designed to enable resources to be better used.

4.2 Case for Change

(Extract adapted from Clinical Case for Change 2017 and 2018)

4.2.1 There are three key challenges within the North Staffordshire and Stoke-on-Trent health economy which have been included in the Case for Change.

4.2.2 Clinical challenge: There is a growing demand for healthcare with an ageing population with long term conditions with entrenched health inequalities. These are coupled with workforce and recruitment challenges.

4.2.3 Estates Challenge: These are not evenly distributed for effective and efficient community service provision, with some estates being built pre 1948 and are in urgent need of repairs.

4.2.4 Financial Challenge: There is a significant deficit for the Community Trust who owns the community hospitals; this is contributing to the significant financial deficit on the whole health economy.

4.2.5 The model of care across Staffordshire is changing as part of the STP with the development of a more community centred service where teams which look after patients are based within hubs in local communities. This review process focuses on the community services – specifically, the clinical model and subsequent options for their delivery. The focus is across two areas:

a) Community beds (the number of beds, how many sites and sites used)
b) Wider Community services (Hub services and Hub provision including community estate)

4.3 Options

4.3.1 On Day Two of the Clinical Senate Review there was a provisional long list of 60 potential options. North Staffordshire CCG and Stoke-on-Trent CCG had developed draft criteria based on a number of key principles to reduce the options to a short list via an expert technical group and proceed to an evaluation. This was scheduled to take place in June.

4.4 Guidance

4.4.1 The panel recognised that the model of care proposed is aligned nationally, as evidenced by the following documents:

a. High quality care for all now and for future generations: Transforming Urgent and Emergency Care Services in England (Revised November 2013)
b. Every One Counts; Planning for patients 2013-14 NHS England
c. The NHS Constitution, (2015) Department of Health
d. Keogh Report - Transforming urgent and emergency care services in England - Guidance for Commissioners regarding Urgent Care Centres (2015) UEC Review Team and Emergency Care Intensive Support Team (ECIST)
e. Urgent Treatment Centre – Principles and Standards (2017) NHS England
f. Next Steps on the Five Year Forward View (2017) NHS England

NHS Outcomes Framework for 2016 – 17 (2016) Department of Health

g. GPFV (2016) General Practice Forward View NHS England April 16

4.4.2 Aligned locally, as evidenced by the:

Joint Strategic Needs Assessment (JSNA) and Health and Well Being Strategy (HWBS). The JSNA and HWBS are produced separately by Staffordshire HWBB and Stoke on Trent HWBB each reflecting the needs of their own local populations.

5. Review and Recommendations

The review and recommendations are presented as per questions agreed within the terms of reference for the review.

Overall the panel was of the opinion that it is important that the Future of Local Health Services in Northern Staffordshire is resolved as the temporary bed closures are resulting in a less strategic approach to the future use of the estate and development of innovative solutions. The CCGs recognise that these proposals need to be consistent with the STP consultation process and the panel are satisfied that at a high level they appear consistent with the STP. The panel also recognised the need for these proposals to be progressed first, given the work to date.

The independent Clinical Review Team did however identify some risks related to system wide alignment and does recognise that patient and public engagement in this change is crucial.

1. **Does the Senate support the proposed clinical model related to the community bed configuration and the hub approach with specific reference to quality, safety and clinical sustainability?**

   KEY FINDING: The panel supports the CCG's general direction and proposals for a reduction in community beds and an increase in place based care through the hub approach. The proposed model is in line with the policy direction set out by Five Year Forward View (FYFV) (NHS2014) and Next Steps FYFV (NHS 2017). The panel separated their views on the community beds from the future hub approach as the hub proposal was still in development and work in progress.

   RECOMMENDATION 1: The business case should reflect the emerging Hub model and any risks and mitigations around the synchronising of this community model. The CCG will also need to evidence the impact on flows and integration with community bed based care

   RECOMMENDATION 2: The panel was unable to ascertain clear workforce plans from the CCG and further detail outlining the workforce across the whole pathway that will deliver the increased place based care, through the hub approach should be provided. This should include a breakdown of current staff, hours of availability and their skills, training strategy and details

of the proposed phasing of training and breakdown of proposed new roles prior. A future recruitment and retention risk assessment should be provided.

KEY FINDINGS: The panel was not able to review the preferred option for the location of community beds and place based care through the hub approach as local processes to ascertain the preferred option were still under way. On 15th June (post review) the CCG shared further information on the outcome of their shortlisting process. The panel has not yet had the opportunity to review this and they are scheduled to meet at a further date as soon as possible, with a view to providing an addendum to this report.

However the panel was in agreement with the following principles of community sites provision.

- The panel **supports** the principle that the Haywood Hospital should have a clear role in the future configuration because of the co-location of services and teams, the range of services provided there, accessibility and the high standard of accommodation.

- The panel is also of the view that having **one site** at Leek Moorlands would be a sensible approach.

- The panel also **supports** consideration of the use of key primary care estate where there are opportunities to co-locate services and utilise high quality facilities such as at the Milehouse site and would also encourage primary care colleagues to consider their active involvement and potential use of community estate such as presents at Cheadle.

- The panel supported the CCGs view that Longton Cottage Hospital was not a viable site.

- The panel noted that stroke and neuro beds are separate from the bed reconfiguration.

RECOMMENDATION 3: The preferred clinical model for the community hospitals, including bed numbers and configuration and other services to be offered from these sites should be described. Information should be provided regarding services available at each proposed community hospital site, including radiology and pathology / patient testing, outpatients etc. to allow for appropriate assessment of patients in the community.

KEY FINDING: The panel considered that the evidence and data presented, suggested that there could be a reduction in length of hospital stay and average length of stay when compared against best practice. The panel was of the opinion that in developing the community bed model, the CCG was in a good position to demonstrate success but needed a more structured approach to evidence the outcomes with appropriate metrics. As the

community beds have been temporarily closed there is the opportunity to further assess key metrics to demonstrate whether this approach has been successful during this period.

RECOMMENDATION 4: The CCG should demonstrate past, current and future states and how progress will be measured going forward in terms of patient benefits and the quality of the new services.

KEY FINDING: The panel identified an area of risk around the quality of nursing homes (CQC 2015) and whether they would be able to deliver proposed expansions, especially when there is higher demand during the winter period.

RECOMMENDATION 5: The CCG should work with local care homes to further test nursing home resilience, capacity and workforce sustainability to provide the flexibility and expansion needed for the new model. The CCG should provide assurance that this specific element of the plan has been tested and is resilient.

KEY FINDING: The panel was of the opinion that the community beds model is CCG driven and recognised different levels of engagement and confidence of system partners in the model. The panel felt there was opportunity for the community trust to be more proactive and align itself and its services more closely with primary care in terms of the integrated out of hospital offer to make it a seamless service. The panel also recognised variable levels of involvement from primary care although saw evidence of innovative thinking and engagement in some local areas but this was not consistent across the whole patch. The panel were unclear on the overall clinical leadership of this proposal for the system and felt the plans could be strengthened in this regard.

RECOMMENDATION 6: Clinical leadership should be strengthened with primary care leading through GP engagement and leadership within local communities. More detailed work needs to be undertaken to ensure that the Acute Trust, Community and Primary Care providers are all are fully engaged and working closely together to develop, promote and deliver the new clinical model.

KEY FINDING: The panel considered that the CCG's Pre Engagement Equality Impact Assessment document was not sufficiently detailed and therefore did not give assurance that the impact of the proposed changes on protected groups and others suffering health inequalities had been adequately considered.

The EIA for options and appraisal was not available to the panel on the day of the visit but has since been provided and will be reviewed on Day 3.

2. Question 2: Is the proposed number of community beds adequate?

KEY FINDING: It was difficult to identify a very specific optimum bed number but the panel accepted the approach and assumptions that the CCG had made when considering this and recognised the additional community investment that had been implemented. The panel also saw evidence that the CCG had built in a level of flexibility to their future plans.

KEY FINDING: The panel was informed that two hospitals had re-opened beds since the community bed closures in Staffordshire albeit it with a different focus: Bradwell Hospital beds have been commissioned as winter surge beds and run by UHNM, the beds are an extension of acute capacity. Brighton House has been introduced into the system as part of the 2017-18 winter plans. The CCG commissioned 25 low level rehab beds at Brighton House to support the system for a period of 12 months. The panel was not assured that if Bradwell and Brighton House beds were closed that there was sufficient capacity in the Staffordshire community bed model to deliver care. The panel recognised that a business case is being developed for additional acute bed capacity on the acute site but the timing of these changes is key to maintaining a safe bed quota, particularly if the Bradwell surge beds close in June as planned.

RECOMMENDATION 7: The CCG should demonstrate strategic alignment with acute beds and the reduction in community beds in North Staffordshire to ensure a greater range of care to patients with better patient flow. Mitigation plans should be clearly captured to address any risks associated with an increase in demand for community care beds.

KEY FINDING: The panel noted that the CCG has used population trends data and predicted future activities to reach conclusions on the number of beds required; and have stated that there will be no material growth in community hospital beds in the near future (NSCCG & ST CCG 2018). The panel was of the opinion that the scenarios used to come to this conclusion were reasonable but not conclusive.

RECOMMENDATION 8: The CCG should establish a process for reviewing the scenarios and assumptions used regarding community bed capacity needed in the future, The current information available is insufficient to give confidence to a precise future capacity level and so the CCG would be better advised to establish potential upper and lower ranges to the current predicted levels which can subsequently be adjusted over time, informed by the available evidence at the time

3. Question 3: Is the commissioned amount of alternative services (e.g. Home First / D2A) adequate?

KEY FINDING: The panel were of the opinion that the Discharge to Assess (D2A) and the Home First Model is comprehensive and developing all the key component parts however the average Length of Stay (LoS) appears high (36 days). The CCG has undertaken a diagnostic to understand the cause.

RECOMMENDATION 9: The CCG should enact the improvements required to reduce LOS.

KEY FINDING: The panel was of the opinion that the overall modelling of the community beds based on the known demand was adequate. The overall capacity modelling could be improved by adding in social care re-ablement demand as a key inter-dependency. The panel was informed that the Home First offer is inclusive of re-ablement and is included in both Staffordshire and Stoke-on-Trent BCF Plans. The model was developed and implemented in conjunction with both Local Authorities (NSCCG & ST CCG 2018).

RECOMMENDATION 10: The links with and provision of social care needs to be described in significantly more detail and take into account any planned council reductions

KEY FINDING: The panel was informed that the CCG commissions a Liaison Psychiatry Service at the Royal Stoke Hospital and Community Hospital (RAID); supporting ward staff caring for people with dementia and supporting the discharge process. The EMI stay at home service provides 72 hour wrap around care on discharge. These services were really well received but the offer post 72 hours in the community was less well articulated.

RECOMMENDATION 11: The CCG should develop further plans to clarify and if appropriate provide and expand support for patients with dementia post the 72 hour period post discharge.

KEY FINDING: The panel was of the view that the integrated local teams are not in direct scope but are a key inter-dependency.

RECOMMENDATION 12: The CCG should ensure that modelling has been undertaken to take into account more detail on the needs of the top risk stratified patients to understand future provision required.

KEY FINDING: The panel did not support the view of Centres of Excellence as a model for frailty and dementia; care should be integral to the place based locality solutions rather than concentrated in one or two centres. The MSK Centre of Excellence was supported as a central service.

Additional Advice System Alignment

KEY FINDING: The panel was of the opinion that it is important that the Future of Local Health Services in Northern Staffordshire is resolved as the temporary bed closures are resulting in a less strategic approach to the future use of the estate and development of innovative solutions. The CCGs recognise that these proposals need to be consistent with the STP consultation process and the panel are satisfied that at a high level they appear consistent with the STP. The panel also recognised the need for these proposals to be progressed first, given the work to date. This will enable any stranded costs to be released back into the system for service investment.

6. References

North Staffordshire CCG and Stoke-on-Trent CCG (2018) PID Discharge to Assess Staffordshire

NHS Confederation(2016) Growing Older Together- Sharing New Ways to Support Older People

Case for Change 2018 North Staffordshire CCG and Stoke-on-Trent CCG

Case or Change 2017 North Staffordshire CCG and Stoke-on-Trent CCG

CQC (to be inserted) Staffordshire & Stoke-on-Trent Partnership NHS Trust (2015)

NSCCG & ST CCG 2018 The Future of Local Health Services in Northern Staffordshire: Presentation to the Clinical Senate Supplementary Information request Post Day 1 Visit 16th May 2018

FYFV (2014) Five Year Forward View NHS England

Next Steps FYFV (2017) Next steps Five Year Forward View NHS England

General Practice Forward View 2016 NHS England

North Staffordshire CCG and Stoke-on-Trent CCG A (2018) long-list to Sort-List Process paper

North Staffordshire CCG and Stoke-on-Trent CCG B (2018) The Future of Local Health Services in Northern Staffordshire – Expert Session 16 May 2018

7. Glossary of Terms

The following list is a glossary of terms used throughout the ICRP report:

5YFV – Five Year Forward View

A&E – Accident and Emergency

CCG – Clinical Commissioning Group

CQC – Care Quality Commission

D2A – Discharge to Assess

ECIP – Emergency Care Improvement Programme

ECIST – Emergency Care Intensive Support Team

EMI – Elderly Mentally Ill

GP – General Practitioner

HBWS – Health and Well Being Strategy

HEE – Health Education England

ICRT – Independent Clinical Review Team

JSNA – Joint Strategic Needs Assessment

LoS – Length of Stay

MSK - Musculoskeletal

PID – Project Initiation Document

RAID – The Rapid Assessment Interface and Discharge service

STP – Sustainability and Transformation Plans

TOR – Terms of Reference

UEC – Urgent and Emergency Care

UHNM – University Hospitals North Midlands

WMCS – West Midlands Clinical Senate

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8. Appendices

8.1 Appendix 1 – Terms of Reference

West Midlands Clinical Senate
NHS England Stage 2 Clinical Assurance
The Future of Local Health Services in Northern Staffordshire
Terms of Reference

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The Future of Local Health Services in Northern Staffordshire

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First published:

Prepared by
Angela Knight Jackson
Head of Clinical Senate
West Midlands Clinical Senate

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TERMS OF REFERENCE

Terms of Reference for: Independent Clinical Review Panel

Topic: West Midlands Clinical Senate NHS England Stage 2 Review
The Future of Local Health Services in Northern Staffordshire
Sponsoring Organisations: North Staffordshire CCG
Clinical Senate: West Midlands Clinical Senate

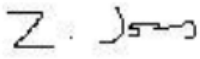
NHS England (Regional or DCO team): West Midlands

Terms of Reference agreed by:

Name  **on behalf of the Clinical Senate**

Sarah Dugan, Chief Executive, Worcestershire Health & Care NHS Trust

Date: 30/05/18

Name  **on behalf of the Sponsoring Organisations**

Zara Jones, Director of Strategy, Planning and Performance, North Staffordshire and Stoke-on-Trent CCGs

Date: Received on 18/05/2018

NB: The following Terms of Reference have been developed using the document 'Clinical Senate Review Process Guidance Notes'. This document should therefore be read in conjunction with the document 'Clinical Senate Review Process Guidance Notes'.

Independent Clinical Review Team Members

Chair:

Name	Position	Organisation
Sarah Dugan Panel Chair	Chief Executive Chief Executive lead	Worcestershire Health and Care NHS Trust Herefordshire and Worcestershire STP

Members:

Name	Position	Organisation
Andrea Westlake	Assistant Head of Nursing and Quality	NHS England – West Midlands
Professor Guy Daly	Pro Vice-Chancellor (Health and Life Sciences)	Coventry University
Paul Maubach	Chief Executive	Dudley Clinical Commissioning Group
Paula Furnival	Executive Director for Adult Social Care	Walsall Council
Dr Simon Harlin	GP Medical Lead, Rapid Response Team	Walsall Healthcare NHS Trust
Dr Shyam Menon	Consultant Gastroenterologist and Clinical Director for Gastroenterology	The Royal Wolverhampton NHS Trust
Nighat Hussain	Programme Director, West Midlands Integrated Urgent Care, Transformation Directorate	Sandwell and West Birmingham CCG
Melvena Anderson	General Manager, Planned Care (Social Work and Mental Health)	Black Country Partnership NHS Foundation Trust
Linzie Bassett	Clinical Team Lead for Stroke and neuro therapies	Birmingham Heartlands and Solihull Hospitals

Jonathan Hopkins	Radiologist	University Hospitals Birmingham
Brendan Young	Patient Representative	N/A
In attendance		
Angela Knight Jackson	Head of Clinical Senate	West Midlands CN and Senate NHS England
Katy Wheeler	Clinical Senate Administrator	West Midlands CN and Senate NHS England

All independent clinical review team members will sign a declaration of conflict of interest and confidentiality agreement (see appendix 1 and 2), and their names and affiliations will be published in the Clinical Senate Stage 2 report.

Aim of the Independent Clinical Review

Consider the potential future model of care for community hospital services and provide an assessment of the extent to which they support the clinical model's potential to deliver quality safety and sustainability services

The Clinical Senate is asked to answer the following questions:
Does the Senate support the proposed clinical model related to the community bed configuration and the hub approach with specific reference to quality, safety and clinical sustainability.
Is the proposed number of community beds adequate
Is the commissioned amount of alternative services (e.g. Home First / D2A) adequate

Scope of the review

The scope of the advice requested did not include reviewing the preferred options for bedded community care as these are still being developed.

When reviewing the case for change and options appraisal the independent clinical review team (ICRT) should **consider whether the model(s) delivers real benefits to patients. The panel should also identify any significant risks to patient care in these proposals.**

The panel should consider benefits and risks in terms of:
Clinical effectiveness
Patient Safety and management of risks
Patient experience, including access to services
Patient reported outcomes

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

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

Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)
Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
Will the proposals reflect further the delivery of the NHS Outcomes Framework?
Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?

Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
Do the proposals support better integration of services from the patient perspective?
Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
Will the proposals help to reduce health inequalities?
Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The ICRT should assess the strength of the evidence base of the case for change and proposed models.

Timeline

The proposed timeline is subject to change. Changes to the timeline may originate from either the Sponsoring Organisation (SO) or Independent Clinical Review Team (ICRT). The ICRT may also take the decision to pause the review in order to gain more information and or expertise. All changes made to the timeline will be updated and circulated to both the SO, NHS England and ICRT by the Clinical Senate (CS).

Week Beginning	Action	Organisation
Jan 18	Sponsoring Organisation (SO) formally requests clinical review of senate as part of NHS England's Stage 2 assurance	SO
Jan 18	Senate council member appoints Chair	CS
March – May 18	Recruitment of Independent Clinical Review Team panel members.	CS
16th April 18	Senate office and SO agree terms of reference (question, timeline and methodology)	CS
16th April 18	Senate Office request documentation from the sponsoring organisation	CS
16th -23rd April 18	Conflict of Interest and confidentiality guidance to the Independent Clinical Review Team	CS
TBC	NHS England Sense Check TOR This is not usually required for North Mids DCO	CS

Week Beginning	Action	Organisation
27th April 12 noon	Documentation received from SO	CS
27th April PM	Documents and Clinical Senate process, governance and guidance dispatched to the independent clinical review team	CS
30th April 18	Independent Clinical Review Team reading	CS
8th May 18	Independent Clinical Review Team meet Clinical review commences in line with TOR and methodology	CS
	Day 1 of Independent Clinical Review Team Context setting, site visit, drafting of TOR with the CCG	CS
10th May 12 noon	Further documentation received from SO	CS
21st May 18	Day 2 of Independent Clinical Review Team	CS
28th May 18	Clinical Senate team Report writing	CS
4th June 18	Draft Report to Independent Clinical Review Team for input and amendments	
11th June 18	Report updated to incorporate amendments	CS
18th June 18	Draft Report to SO for fact checking (5 day Turnaround)	CS
25th June 18	Finalise report	CS
25th June 18	Sign off by Clinical Senate Council	CS
25th June – 2nd July 18	Formally submit final report to SO	CS
TBC	Publish and disseminate as per terms of reference	CS

Methodology

The role of the independent clinical review team will be to examine documentary evidence, carry out site visits if necessary and decide recommendations. The independent clinical review team may decide to increase or decrease the number of days required for review and also the method by which panel members provide input into the review.

It is anticipated that the review will be over 2 days and will take place on the following dates:

8th May 2018
21st May 2018

The independent clinical review team will need to consider the following bullet points 5-9:

Reporting

A draft report from the Independent Clinical Review Team will be made available to the sponsoring organisation for fact checking prior to publication. Any comments / corrections must be received within 5 working days.

The Independent Clinical Review Team will submit a draft report proportionate to a Stage 2 review (see as a guide Clinical Review Team Report Template appendix 3) to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report. The council may wish to take a view or offer advice on any issues highlighted that should be taken into consideration in implementing change.

The Council will be asked to comment specifically on the:

Comprehensiveness and applicability of the review
Content and clarity of the review and its suitability to the population in question
Interpretation of the evidence available to support its recommendations
Likely impact on patient groups affected by the reconfiguration
Likely impact / ability of the health service to implement the recommendations

The final report will be submitted to the sponsoring organisation by week commencing TBC 2018 and the clinical advice will be considered as part of the NHS England's Stage 2 Assurance process for service change proposals. The report is not expected to comment upon issues of the NHS England assurance process that will be reviewed elsewhere (e.g. patient engagement, GP support or the approach to consultation).

The review report will remain confidential until placed in the public domain at the conclusion of the review process with the agreement of the sponsoring organisation.

Communication and Media Handling

The Clinical Senate will ensure all communication activities, in whatever form, are conducted according to appropriate ethical, legal and professional standards, using professional guidance from in-house communications teams and or contracted external teams.

The Clinical Senate review will be published on the website of the Clinical Senate with the agreement of the Sponsoring Organisation. Council and assembly members will provide support to disseminate the review at a local level. The Clinical Senate may engage in various activities with the sponsoring organisation to increase public, patient and staff awareness of the review

Resources

The West Midlands Clinical Senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

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

Accountability and Governance

The independent clinical review team is part of the West Midlands Clinical Senate accountability and governance structure.

The West Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

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

Functions, Responsibilities and Roles

The Sponsoring Organisations

The Sponsoring Organisations will:

Provide for the clinical review panel all 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, 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).

Respond within the agreed timescale to the draft report on matter of factual inaccuracy.

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

Submit the final report to NHS England for inclusion in its Stage 2 formal service change assurance process.

The Clinical Senate Council and the Sponsoring Organisations

The Clinical Senate Council and the Sponsoring Organisations will:

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

Clinical Senate council will:

- Appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and report
- provide suitable support to the team.
- Submit the final report to the sponsoring organisation

The Independent Clinical Review Team

The Independent Clinical Review Team will:

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template proportionate to Stage 2 review process and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- 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
- keep accurate notes of meetings.

The Independent Clinical Review Team Members

The Independent Clinical Review Team members will undertake to:

- Commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

NHS England

NHS England will:

- Sense check the TOR to ensure that the review will deliver the views that address DCO concerns raised during the assurance process
- Requests to change the TOR should be made through the commissioner of the review

Appendices

Appendix 1

Declaration of Conflict of Interest

West Midlands Clinical Senate
Stage 2 Clinical Assurance Independent Clinical Review

The Future of Local Health Services in Northern Staffordshire

To be completed by all members of the clinical review team. Clinical Senate Council members should also consider if they have any conflicts in considering the review team's report.

For advice on what items should and should not be declared on this form refer to the 'Conflicts of Interest Policy' issued by the West Midlands Clinical Senate. Further advice can also be obtained from the Clinical Senate Manager.

Name: _____

Position: _____

Please describe below any relationships, transactions, positions you hold or circumstances that you believe could contribute to a conflict of interest:

Type of Interest – Please supply details of where there is conflict in accordance with the following list:

A direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

An indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

A direct non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

An indirect non-pecuniary interest: where an individual is closely related to, or in a relationship, including friendship with an individual.

A direct non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

An indirect non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value but is a benefit to peers or colleagues (for example, a recommendation which results in an increase in revenue or status to their employing organisation or results in their organisation becoming the preferred provider).

An indirect non-pecuniary conflict: where the evidence of the senate may bring a member into direct or indirect conflict with their contracting or employing organisation, to the extent that it may impair the member's ability to contribute in a free, fair and impartial manner to the deliberations of the senate council, in accordance with the needs of patients and populations.

Other – please specify

Name	
Type of Interest	
Details	
Action Taken	
Action Taken By	
Date of Declaration	

I hereby certify that the information set forth above is true and complete to the best of my knowledge.

Signature: _____

Name: _____

Date: _____

Appendix 2

Confidentiality Agreement
West Midlands Clinical Senate Independent Clinical Review Team
The Future of Local Services in Northern Staffordshire

I (name) …….
hereby agree that during the course of my work (as detailed below) with the West Midlands Clinical Senate I am likely to obtain knowledge of confidential information with regard to the business and financial affairs of an NHS body, or other provider, its staff, clients, customers and suppliers, details of which are not in the public domain ('confidential information') and accordingly I hereby undertake to and covenant that:

I shall not use the confidential information other than in connection with my work; and

I shall not at any time (save as required by law) disclose or divulge to any person other than to officers or employees of West Midlands clinical senate, other NHS organisations, staff, clients, customers and suppliers whose province it is to know the same any confidential information and I shall use my best endeavours to prevent the publication or disclosure of any confidential information by any other person.

The restrictions set out above shall cease to apply to information or knowledge that comes into the public domain otherwise than by reason of my default of this Agreement.

The 'Work' (clinical review) is: North Staffs Community Bed Review

Signed _____ Date: _____

Name (caps) _____

Appendix 3

West Midlands Clinical Senate Independent Clinical Review Team Report Template

West Midlands Clinical Senate
The Future of Local Health Services in Northern Staffordshire
Review

[senate email]@nhs.net

Date of publication to sponsoring organisation:

CHAIR'S FOREWORD (Independent Clinical Review Team)

Statement from Clinical Senate Chair

SUMMARY & KEY RECOMMENDATIONS

BACKGROUND

[CLINICAL AREA]
[Description of current service model]
[Case for change]
[Review methodology]
Details of approach taken, review team members, documents used, sites visited, interviewees]
[Scope and limitations of review]
[Recommendations]

CONCLUSIONS AND ADVICE

[References]

This should include advice against the test of 'a clear clinical evidence base' for the proposals and the other checks defined in the terms of reference agreed at the outset of the review.

Has the proposal been founded on robust clinical evidence? What evidence has been used and how has it been applied to local circumstances?

Has the available evidence been marshalled effectively and applied to the specifics of the proposed scheme?

GLOSSARY OF TERMS

APPENDICES:

Terms of Reference
Independent Clinical Review Team Members biographies and any declarations of interest
Background-

(NB this should be a summary and is not intended to be the set of evidence or information provided)

8.2 Appendix 2 – ICRT Panel Members' Biographies

Name	**Sarah Dugan**
Sarah is the Chief Executive of Worcestershire Health and Care NHS Trust and Chief Executive Lead for the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP). Sarah is a Registered General Nurse, Registered Sick Children's Nurse and Health Visitor and has a Masters degree in Health and Social Care Management. She has held a wide range of senior positions within provider and commissioning organisations and has a particular interest in partnership working, integration and the development of positive learning cultures.	

Name	**Andrea Westlake**
Andrea has extensive experience in the NHS since 1985, as a Midwife, Health Visitor and Commissioner. Andrea has an award winning background, including being awarded a Fellowship of the Institute of Health Visiting for services to public health nursing. Andrea has worked at national, regional and local levels in health and local government, more recently as Deputy Director of Nursing and Quality for NHS England (West Midlands). Andrea has led a number of strategic improvement and workforce development programmes and is an Associate of the Faculty of Sustainable Improvement (NHS England).	

Name	**Professor Guy Daly**
Guy is Pro-Vice-Chancellor (Health and Life Sciences) at Coventry University. He is a member of various national and local groups and bodies including: Council of Deans of Health Executive, West Midlands Clinical Senate, West Midlands Combined Authority Wellbeing Board, Coventry Health and Wellbeing Board, and Coventry and Warwickshire Partnership NHS Trust. He is a member of the Coventry and Warwickshire Sustainability Transformation Partnership *Better Health - Better Care - Better Value* Board and chairs its Clinical Design Authority Board. He is a social policy academic and his research interests are in social care (personalisation, choice, adult social care), housing policy, local government, and the governance of public services generally. He is an active member of the Social Services Research Group and is currently Joint Editor of its journal, Research Policy and Planning. Recently, he has been developing partnerships with Indonesia's government and universities in relation to nursing workforce and assisting with the evaluation of Indonesia's recently introduced social insurance health system (BJPS). He is a trustee and current chair of the third sector social policy think-tank, The Human City Institute (HCI), as well as a trustee of Research in Specialist and Elderly Care (RESEC), a charity which aims to improve the quality of research in specialist and elderly care.	

Name	**Paul Maubach**
The role of Chief Executive Officer means that Paul has overall responsibility for meeting the needs of Dudley and Walsall patients, CCG employers, the taxpayer, the wider membership and partnerships, and the law and statute within which the CCG operates. Paul also undertakes developing the joint working with partners across the Black Country. Paul leads the programme for developing the Dudley Multispecialty Community Provider which is intended to deliver improved, integrated care for our population.	

Name	**Paula Furnival**
Paula is the Executive Director of Adult Social Care in Walsall Council with responsibility for 500+ staff, £115m budget and the statutory Director of Adult Social Services (DASS). She has experience in public services in local government and the NHS Paula has been the Operations Director of an Integrated Health Care Trust which she helped establish in 2010. She has undertaken sector led inspections, peer reviews and is a qualified coach.	

Name	**Dr Simon Harlin**
Simon is a GP who has been working with Walsall Healthcare NHS Trust since 2011. He works across the Acute and Community boundary with a team of nurses and therapists to support older people with urgent care and medical needs at home. He has helped in the evolution and development of both Community and Acute services in Walsall that focus on the care of people with complex needs and frailty. He has also been part of the West Midlands Quality Review Service's development of quality standards for the care of people living with frailty, and has undertaken a number of service reviews with them.	

Name	Shyam Menon

Dr. Shyam Menon is a Consultant Gastroenterologist and HPB Physician and Clinical Director of Gastroenterology at The Royal Wolverhampton NHS Trust. He manages one of the largest gastroenterology clinical services in the West Midlands. He is a member of the pancreas section of the British Society of Gastroenterology and the West Midlands HPB expert advisory group. He trained in the West Midlands and undertook a HPB fellowship in Liverpool in addition to observerships in Indiana, Montreal, Marseille and Brussels.

He completed an MD thesis from the University of Birmingham during his training and has masters degrees in Epidemiology, Nutritional Medicine and Healthcare leadership. He leads a tertiary HPB endoscopy service between Wolverhampton and the Queen Elizabeth Hospital in Birmingham and has active research interests in pancreaticobiliary medicine and endoscopy.

Name	Nighat Hussain

Nighat is an experienced director and works as a transformation programme lead within the West Midlands Integrated Urgent Care (IUC) Team. She supports the West Midlands Urgent and Emergency Care Development forum and transformation programme for IUC. She has led on the programme management of a complex regional stroke programme within Birmingham, Solihull and Black country conurbation. Nighat has worked closely with Professor Tony Rudd (National Clinical Director for Stroke) to develop the NHS (2016) stroke services: Configuration Decision Support Guide. She has directed multiple reconfigurations for the Right Care Right Here Programme Board (urgent and emergency care, urgent cardiology and surgery); overseeing several listening exercises and programme governance within tight timescale.

Nighat has over 20 years of experience working in hospital, commissioning and programme management settings. Nighat has extensive knowledge and experience in service re-design in both an acute hospital and commissioning environment. She has successfully taken transformation proposals through the NHSE assurance process, this has required building robust business cases including developing robust quality standards and clinical pathways.

She has also led on an acute contract process including developing commissioning intentions; led the process to embed the changes in the contractual activity baseline and Service Delivery and Improvement Plan. She is extremely passionate about service transformation and has extensive knowledge of operational including programme and project management, especially within modernisation and clinical pathways.

Name	**Melvena Anderson**
Melvena was appointed as General Manager in January 2014 in Black Country MH FT Trust, having previously held position of Divisional Manager. Prior to that she held positions as Service Manager, Assistant General Manager with experience also of working as a Commissioning Support manager in PCT. Melvena started in Local Authority as a Social Worker in 1994. She has a successful record in managing a range of complex health and social care services and has spent the majority of my career leading operational delivery and numerous transformation and service redesign programmes across a range of acute, community and primary care settings. Melvena is also the Freedom to speak up champion for the trust and also a Dignity champion and has completed a Post Graduate in Health and Social Care management.	

Name	**Linzie Bassett**
Linzie is a HCPC registered Physiotherapist who qualified in 1988 from Queen Elizabeth School of Physiotherapy Birmingham. She has always had a strong interest in treating neurological conditions and was awarded a Fellowship by the CSP in 2007 for her contribution to neurophysiotherapy and development of ACPIN. She is currently working for Heart Of England Foundation Trust where her leadership skills have enabled her to work as a Therapy Clinical team lead for a group of Physiotherapists, Occupational Therapists, dietitians and speech and language therapists within Stroke and Neuro. Her clinical skills include the assessment and treatment of a complex caseload of neurological patients. Linzie has a keen interest in service development and patient experience.	

Name	**Jonathan Hopkins**
Native to Birmingham. Also has connection to South West Shropshire (Bucknell) Schooled at King Edwards VI Five Ways. University Nottingham Operating Department Orderly at Birmingham Maternity Hospital Medical training: Nottingham, Derby, Manchester, Fort William, Glasgow & Birmingham Consultant Interventional Radiologist since 2004, University Hospital Birmingham. Honorary Senior Clinical Lecturer at University of Birmingham. Specialist Senior Lecturer at Birmingham City University. RCR College Tutor since 2006 RCR Regional Chair West Midlands since 2013 Chair, Physics Examination Committee (CR) RCR since 2016 Head of School (elect) HEE(WM) School of Radiology	

Name	**Brendan Young**

Having had a career in the Healthcare Industry, Consultancy & Coaching, Brendan has extensive experience of partnership working with NHS Clinicians, Commissioner & Provider organisations to improve Quality outcomes and safety for patients.

Over the past decade, Brendan has been involved in many successful Co-Production initiatives between patients and the NHS.

His post-graduate qualifications and wide experience of Organisational Development & Change within the NHS helps him understand culture, values and staff motivations supporting innovation and improvement. He is a Chartered member of CIPD.

Brendan engages extensively with patients, carers/supporters and Healthcare Professionals and Managers at all levels and this helps him provide an informed patient voice and insight to a number of NHS bodies on which he serves in a voluntary basis. He is a patient representative on the West Midlands Clinical Senate Council and the NHS England West Midlands STP Stroke Working Group and AF Collaborative Group and serves on the Worcestershire Stroke Strategy Forum and the Hereford & Worcs Stroke Programme Board.

He has extensive experience of patient service improvement within his Clinical Senate and Worcestershire Clinical Commissioning Group local NHS Trust roles.

He is a qualified Wellbeing Coach with interests in Positive Psychology and provides Wellbeing support within the Voluntary sector for those having lived experience and recovering from Physical and Mental Health conditions.

8.3 Appendix 3 – Agenda – Day 1

8.3.1 Day 1 Group A

DAY 1

Independent Clinical Review Panel
Stage II Clinical Assurance of
The Future of Local Health Services in Northern Staffordshire
Tuesday 8th May 2018
Venue – Site Visits –Stoke on Trent and North Staffordshire
AGENDA

Timing			
07:57	Train will depart from Birmingham New Street		
08:53	Train will arrive at Stoke-on-Trent Train Station		
09:00	Arrival and refreshments		
09:30	Welcome and Introduction, overview and key lines of enquiry		Clinical Senate only
10:30	Welcome and Introductions		Stoke on Trent and North Staffordshire CCG
10:35	Presentation and Questions		Clinical Senate & Stoke on Trent and North Staffordshire CCG
11:30	Split into groups of 3 Group A – Leek Group B – Cheadle and Longton Group C – Haywood and Bradwell		
12:30	Group A – Arrive at Leek Hospital		
12:30	Lunch		
13:15	Site Visit – Leek Hospital		
14:15	Travel to CCG		
15:00	Q&A		Clinical Senate & Stoke on Trent and North Staffordshire CCG
16:00	Travel to Stoke-on-Trent Train Station		
TBC	Train departs from Stoke-on-Trent Train Station		

8.3.2 Day 1 Group B

DAY 1

Independent Clinical Review Panel
Stage II Clinical Assurance of
The Future of Local Health Services in Northern Staffordshire
Tuesday 8th May 2018
Venue – Site Visits –Stoke on Trent and North Staffordshire
AGENDA

Timing			
07:57	Train will depart from Birmingham New Street		
08:53	Train will arrive at Stoke-on-Trent Train Station		
09:00	Arrival and refreshments		
09:30	Welcome and Introduction, overview and key lines of enquiry		Clinical Senate only
10:30	Welcome and Introductions		Stoke on Trent and North Staffordshire CCG
10:35	Presentation and Questions		Clinical Senate & Stoke on Trent and North Staffordshire CCG
11:30	Split into groups of 3 Group A – Leek Group B – Cheadle and Longton Group C – Haywood and Bradwell		
12:00	Group B – Arrive at Cheadle Hospital		
12:00	Site Visit – Cheadle Hospital		
12:45	Lunch		
13:15	Travel to Longton Hospital		
13:45	Site Visit – Longton Hospital		
14:45	Travel to CCG		
15:00	Q&A		Clinical Senate & Stoke on Trent and North Staffordshire CCG
16:00	Travel to Stoke-on-Trent Train Station		
TBC	Train departs from Stoke-on-Trent Train Station		

8.3.3 Day 1 Group C

DAY 1
Independent Clinical Review Panel
Stage II Clinical Assurance of
The Future of Local Health Services in Northern Staffordshire
Tuesday 8th May 2018
Venue – Site Visits –Stoke on Trent and North Staffordshire
AGENDA

Timing			
07:57	Train will depart from Birmingham New Street		
08:53	Train will arrive at Stoke-on-Trent Train Station		
09:00	Arrival and refreshments		
09:30	Welcome and Introduction, overview and key lines of enquiry		Clinical Senate only
10:30	Welcome and Introductions		Stoke on Trent and North Staffordshire CCG
10:35	Presentation and Questions		Clinical Senate & Stoke on Trent and North Staffordshire CCG
11:30	Split into groups of 3 Group A – Leek Group B – Cheadle and Longton Group C – Haywood and Bradwell		
12:00	Group C – Arrive at Haywood Hospital		
12:00	Site Visit – Haywood Hospital		
13:00	Lunch		
13:30	Travel to Bradwell Hospital		
14:00	Site Visit – Bradwell Hospital		
14:45	Travel to CCG		
15:00	Q&A		Clinical Senate & Stoke on Trent and North Staffordshire CCG
16:00	Travel to Stoke-on-Trent Train Station		
TBC	Train departs from Stoke-on-Trent Train Station		

8.4 Appendix 4 – Agenda – Day 2

DAY 2

Independent Clinical Review Panel
Stage II Clinical Assurance of The Future of Local Health Services in Northern Staffordshire
Monday 21st May 2018
Venue – Park Regis, Birmingham, 160 Broad St, Birmingham B15 1DT
AGENDA

Item			Purpose
09:00		Arrival with Refreshments Panel Pre-meet	
09:30	1	Introduction by the Chair	Introductions, housekeeping
09:35	2	Update	New Panel Member Update
09:50		• Panel Discussion – Review of Day Two • Scope of Terms of Reference • Key Lines of Enquiry • Further Documentation Submitted	Review ToR Overview of documentation Formulate questions / areas of clarification for Commissioners
10:30		Panel Discussion – Key Lines of Enquiry	Explore and clarify specific issues Formulate questions for Commissioners
11:00		Refreshments	
11:15		Programme Board Follow up Q&A (sponsoring organisation)	Commissioners Q&A – outlining of options
12:30		Lunch & Refreshments	
1:15		Panel Deliberations *1:20 – 1:35 call Dr Gilby* *1:40 – 1:55 call Dr Iqbal*	Assess evidence presented, Agree, Capture themes
2:45		Refreshments	
3:00		Panel Deliberations – Post Day 2	Next Steps
4:00		ICRT Chair, Vice Chair, Clinical Senate Team Debrief with Sponsoring Organisation Teleconferencing Details Dial In 0800 915 1950 or 0203 463 9697 Participant passcode: 47598189 then #	Debrief Report writing process
4:30		END	

8.5 Appendix 5 – List of Evidences

Checklist Information from NS and SOT CCG: Evidence – Day 1

Topic Area	Evidence
1. Setting	• Background – demography and service activity at community hospitals • Discharge to Assess (D2A) PID
2. Model proposed	• Clinical case for change citing national best practice
	• Options Appraisal process
	• Proposed Model of Care • Integrated Care Team specification • D2A PID • D2A Modelling • Workforce and clinical model • Workforce Plan on a Page
	• Case for Change
	• Quality Impact Assessments
	• Proposed Model of Care, Key Benefits • Integrated Care Team specification • D2A PID
	• Case for Change
	• Original EIA for beds • Quality Impact Assessment
	• Pre-consultation activity log • Pre-consultation engagement outline
3. Clinical Engagement	• Proposed Model of Care • Case for Change • Integrated Care Service Specification
4. Best Practice	• STP documents • Commissioning intentions • Quality Impact Assessment • Report from CEO and Chief Execs Forum • List of national guidance/evidence • Workforce strategy

	• GP Hubs - including the following services:
	  ○ GP Same day
	  ○ LTC Clinics
	  ○ DN Clinics
	  ○ Physiotherapy
	  ○ Phlebotomy

	○ Podiatry • Planned care - including: ○ IMPACT ○ MSK ○ Rheumatology ○ Supportive Therapies • Dementia • UTC • Fracture Clinic • Diagnostics – including: ○ X-Ray ○ Non Obstetric Ultrasound • Step up beds • Step down beds
5. Implementation and Clinical Outcomes	• Estates plans
	• Proposed model of care • Integrated Care Team specification
	• Proposed model of care
	• Stoke on Trent Health Profile • Stoke on Trent_Joint_Health_and_Wellbeing_Strategy_2016-20 • Staffordshire-Joint-Strategic-Needs-Assessment-Profile---November-2014 • Staffs_Health-and-Wellbeing-Outcomes-Report-February-2018-Summary • Wellbeing Boards
	• Financial Summary • Travel distance • Outline of investment prior to bed closure • Workforce requirement - GPFV STP Workforce Plan - Staffordshire trajectory – assumptions - Plan on a page • Estates solutions • Workforce baseline - Workforce and clinical model • Service specifications i.e. Marrow House
6. Additional Documents	• EIA of the pre-consultation process • Original EIA for beds • Quality Impact Assessment • Improvement and Assessment Framework

Checklist Information from NS and SOT CCG: Evidence – Day 2

	Evidence
1.	PID – Community Hospitals Northern Staffordshire and Discharge to Assess
2.	PID – Integrated Community Teams – incorporating Frail Elderly and LTCs
3.	Integrated Care Teams – Staffordshire Service Specification Version 1.2 DRAFT
4.	Risk Register (covering Commissioning, Quality, Finance, Organisational Development, Primary Care and Planning & Performance)
5.	The Future of Local Health Services in Northern Staffordshire – Expert Session 16 May 2018
6.	The Future of Local Health Services in Northern Staffordshire – Presentation to West Midlands Clinical Senate Council – 16 May 2018

Produced by:
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