NHS

South West Clinical Senate

Stage Two Clinical Review Report

NEW Devon Clinical Commissioning Group's Proposals to Changes to Community Beds

27th September 2016

Final

Document Title: Stage Two Clinical Review Report: NEW Devon CCG's Proposals to Changes to Community Beds

Version number: 2

First published: 21st September 2016 in draft format

Updated: 27th September 2016 Final Version

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Signed off by: Phil Yates, South West Clinical Senate Chair

1 Executive Summary

1.1 Chair's Summary

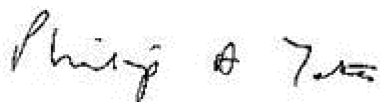
This report has been produced by the South West Clinical Senate for NEW Devon Clinical Commissioning Group (CCG) and provides recommendations following a clinical review panel that was convened on 15th September 2016 to consider the CCG's proposed reduction in community beds in its East Devon locality.

This was an independent review carried out as part of the NHS England stage 2 assurance checkpoint which considers whether proposals for large scale service change meet the Department of Health's 4 tests for service change prior to going ahead to public consultation, which in this case is planned for October 2016. The Senate considers test 3, the evidence base for the clinical model as an independent clinical advice giving body.

Whilst the review panel concluded that it broadly supports the CCG's proposals for a reduction in community beds, this report draws attention to a number of key areas where additional detail will support the proposals and provide assurance around the implementation process and how re-provision of community services will be delivered when beds are closed. **The panel recommends that with respect to the clinical basis for the model, the consultation should proceed; but with assurance provided to NHS England that certain criteria are met as part of its gateway process prior to implementation.**

The CCG has been working at pace on these proposals and in recognition of the short timescales, the Senate has taken a number of steps to expedite the review process.

I would like to thank everyone who has co-operated in this process.



Phil Yates, Clinical Chair, South West Clinical Senate

1.2 Summary Recommendations

The South West Clinical Senate Review panel concluded that it broadly supports the CCG's proposals for a reduction in community beds replaced by an increase in place based care. There are areas where it believes further information or development work is needed to strengthen the plans. The panel has consequently made a number of recommendations which, when addressed, will add to the ability to deliver sound clinical care under the proposed model.

The issues highlighted here are broadly the same as those identified in the early sense check advice provided by the Senate in June although the proposal has since been honed to focus only on the reduction of the Eastern locality community beds at this stage.

The issues detailed in the recommendations below do not need to be resolved prior to consultation but do need to have been explored in much more depth prior to implementation with assurance that this has been done provided to NHSE. The panel concurred that the evidence for change is clear but would like to see evidence of further work to demonstrate that the clinical model and anticipated benefits for patients are deliverable and sustainable.

Overall Recommendation
The South West Clinical Senate Review panel supports the CCG's proposals for a reduction in community beds replaced by an increase in place based care. The proposed model is in line with the policy direction set out by Five Year Forward View. The Senate's literature search and ongoing review in this area suggests that this is an emergent area for research and evaluation (a summary is attached in appendix 10).

<u>Prior to closure of the beds and implementation of its proposed model the Clinical Senate recommends that the following issues are addressed;</u>

Principle Recommendation

1. Further detail outlining the workforce that will deliver the new clinical model must 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 to bed closures. A future recruitment and retention risk assessment should be provided.

Main recommendations

1. Detail outlining how the vision for re-provision of community services and place based care will work in the Eastern Locality when beds close (eg. community MDTs, rapid response and community connectors as described in proposals), linked to the workforce to deliver it, is essential. This must also include a breakdown of the CCG's current 'community assets' available to deliver place based care.

2. A clinical model for the community hospitals, including beds and other services should be described. Information should be provided regarding services available at each proposed community hospital site, including radiology and pathology / near-patient testing, to allow for appropriate assessment of patients in the community without immediate recourse to the acute hospital as the de facto option.

3. The links with and provision of social care needs to be described in significantly more detail and taking into account planned council reductions in care package provision vis a vis the

proposed increase in place based care for medically fit patients. This should include social care metrics.

4. Clarification regarding how the remaining community hospital beds will be used more effectively and how “active rehabilitation” will be delivered must be provided.

5. Detail of further stages of development in the Success Regime programme along with timelines and outline clinical models for example in relation to the creation of clinical hubs and acute care transformation are required. The impact these changes could have in the Eastern locality once beds are closed needs to be considered as well as the impact across CCG and STP borders in particular accounting for SDT CCG community transformation plans and the use of Derriford hospital.

6. More evidence about the experience of previous service change in North Devon, including how many people are now managed in the community, how non-bedded community services are delivered, the link with and impact on social care provision and the impact of these changes on patients should be provided (and collected if not already available). This should include detail of community staffing arrangements and training. Please set out any similarities and differences between the demographics of North and East Devon.

7. The metrics to record outcomes for the future model of care in the Eastern locality are clarified. Eg. numbers of pressure ulcers (evidence suggests these go up in proposed type of model). Where health care performance indicators are used (eg. emergency admission/re-admission rates to hospital following community bed closures), social care metrics ideally need to sit alongside them. These could include data on community care packages and care home referrals/admissions plus any outcome measures available (eg. ASCOF Framework 2015/16).

8. A greater consideration of opportunities to use technology and link up existing IT needs to be demonstrated in the proposals for developing place based care. This could support people in their own homes, enable patient flow and create better connections between community hospitals and acute hospitals.

9. A review of residential and nursing home bed capacity and utilisation has not been seen and should be provided.

10. Radiology access across the patch both for community inpatients and community clinics following any hospital closures needs to be considered to avoid sending patients into acute hospitals for x-ray and ultrasounds only. How this fits with urgent care centres should also be explained.

11. No audit of the 60 bed unit at Mount Gould was included in the acuity data and this should be undertaken.

12. Mental health provision as part of the place based care model has not yet been accurately described and needs to be.

13. Early identification of patients at risk as a key tenet of the place based care model needs to include focus on populations rather than individuals to ensure unmet need is picked up and that interventions begin at age 50 to stem future demand.

14. A staged closure of the beds in the Eastern locality is mapped out to manage risk and unforeseen consequences.

Additional Comments

- GPs are little referenced in the proposals. How they realistically link into placed based care and any impact upon them or unintended consequences need to be considered.
- Plans for engaging with grassroots staff need to be clearly set out and implemented to support change.
- The national and international evidence base for harm associated with conventional bed-based care should be set out clearly in documentation.

2 Background

The Clinical Senate Review Process is used across England to provide independent clinical review of large-scale service change to ensure there is a clear clinical basis underpinning any proposals.

Reviews are undertaken as part of the NHS England assurance framework. The local assurance team involved the Senate in NEW Devon CCG's proposals at Stage One of the framework when an initial sense check was provided. This review report concludes the stage 2 checkpoint which considers whether proposals meet the Department of Health's 4 tests for service change prior to going ahead to public consultation. The Senate considers test 3, the evidence base for the clinical model as an independent clinical advice giving body.

The NEW Devon CCG proposal is to reduce the number of community hospital beds from 143 to 72. The context for this change is set out below and describes how quality of care for patients needs to be improved as well as providing the rationale for improving productivity.

The Review Process

The Senate panel reviewed both the documentation provided by the CCG for this model of care as well as local and national evidence. It had two preliminary meetings with the CCG before hearing its proposals for change at a formal clinical review panel meeting. This provided an opportunity for the CCG to present its proposals and for the panel to discuss the proposals, ask questions and raise concerns.

At the review panel, the Senate stressed to the CCG that it regards its role as being a supportive one, raising legitimate clinical concerns aimed at strengthening the clinical case for change, identifying potential gaps and ensuring that the CCG's process is as robust and well thought-out as possible.

3 Local Context

North, East and West (NEW) Devon CCG is the largest in the country and covers a largely rural population of 883,000 people in the South West of England. People in the region as elsewhere in the country are living longer, with increasingly complex care needs that require more support from

health and social care services. The CCG reports 40% of local people using almost 80% of health and social care services and 280,000 people are living with one or more long-term condition, such as asthma, diabetes, hypertension, cancer and mental illness. The cost of providing health and social care is rising due to demand from the increasing age and ill-health of local people and the costs associated with keeping pace with new technology.

Local health and social care services are under severe financial pressure, and as a result are likely to be £398m in deficit by 2020/21. Commissioners and providers of health services in North, East and West (NEW) Devon became part of the Success Regime in 2015, a national initiative to “protect and promote services for patients in local health and care systems that are struggling with financial or quality problems, or sometimes both”. Phase 2a of the Success Regime outlined a series of opportunities for the healthcare system to explore further. In Phase 2b some of these opportunities were shortlisted into preferred possible options for service change, of which the proposed reductions to community beds is one stage in the wider Success Regime programme.

The CCG describes care in NEW Devon as needing to be more person-centred and co-ordinated, especially for people with more than one long-term condition and for those with a mental illness. There are also difficulties with recruiting and retaining staff at all levels, making it hard to provide comprehensive and high quality services.

In a 2015 audit the CCG recorded that half of all people admitted to local acute hospitals stay longer than 10 days and around one third of people are considered medically fit to leave hospital but can’t, particularly patients over the age of 70. Over half the people who are fit to leave the community hospital have been waiting to leave for at least four days. Ten per cent of admissions are considered preventable.

4 Strategic Sense Check Input

Prior to agreeing to undertake a formal stage 2 clinical review, NEW Devon CCG asked the Clinical Senate to review its Success Regime Phase 2a draft recommendations. The objective was to undertake an initial informal sense check and provide comments on the work to date. The Clinical Senate Council met on 19 May 2016 and at this meeting reviewed the summary slides provided by the CCG. Following this, a working group of four council members undertook a desktop ‘read and review’ of the following documents, which are included in the appendix:

1. Wider Devon STP April submission (Appendix 8a)
2. Case for Change Final (Appendix 8b)
3. Phase 2a Draft Recommendations (Appendix 8c)
4. Phase 2a Summary Slides for Senate (Appendix 8d)

For the Strategic Sense Check, Senate Council members used the following questions which also form the basis of a full review, to analyse the clinical evidence base for change.

- Is the clinical case for change robust?
- Will the proposed changes improve the quality of care?
- Is the change clinically led?
- Is the change based on a clear evidence base?

- Does the clinical case for change fit with the proposed changes?
- Does the clinical case fit with national best practice and clinical sustainability?

4.1 Summary Advice from Sense Check

"The documents submitted provide an excellent analysis of the local health service situation. The suggested solutions are very similar to those being tried elsewhere. The case for change is generally logical and clinically sound. However, the type of large-scale change proposed in Devon is multi-faceted. Further information will need to be included in the options appraisal and pre-consultation business plan to link the clinical case for change to the specific changes being proposed and to demonstrate anticipated achievability and effectiveness.

The clinical case for change for each work-stream needs to be considered individually. It is important to gather evidence of effectiveness, to set out how demand will be managed and to compare outcomes between the different service models. For example, there are several references to the workforce taking on radically new roles but there is no specific detail about what that means. This makes it impossible to know whether it will be effective, what it will cost, whether it is achievable, over what time period etc. There is also a need to model how the investment suggestions will translate into financial sustainability."

5 NEW Devon CCG's Proposal

The CCG team delivered a presentation (appendix 11) at the stage two review panel meeting on 15th September to complement the pre-reading pack already shared and to update the panel with the refined proposals on which the CCG intends to consult from October.

The presentation described the current financial pressures faced by the CCG as well as a 2015 audit which identified around 500+ patients medically fit and waiting to leave hospital beds who don't need to be there. Current services are fragmented, causing duplication of effort, delay and too much reliance on bed-based care. Staying any longer than necessary in hospital has been shown to have potential negative effects on patients – they may experience reduced muscle function, a decline in independence and mobility and a risk of infection. It is also expensive. There is a lot of space in community hospitals that is not being used (up to half the space in some hospitals) and the average cost per day is as much as £380 (for staff and apportioned estate costs).

The proposal under review is to reduce community hospital beds from 143 to 72 in the Eastern locality by implementing the service model that has already been pioneered in Northern Devon, and applying the same ratio of beds per head (weighted population) as there. The intention is to secure a modest investment in community services to absorb the reduction in bed-based activity. These services will include:

- **A single point of access**, described as;
  Available 24/7 with a 2hr response time. Referrals from any service would be received by a clinician with: core knowledge and specific training in triage, access to the comprehensive assessment record, and knowledge of community-based and voluntary sector services. The service would determine the most appropriate first responder for the patient.

File path:

- **A rapid response service**, described as;
  A multidisciplinary team including community nursing, therapists, health and care assistants, voluntary sector agencies, access to medical input, prescribing appropriate to scope of practice, mental health workers, administration support & domiciliary care workers. The team would undertake an initial assessment of need and then institute a package of care at home, including: nursing, therapies, domiciliary support and night-sitting. The rapid response team would also support patients in residential and care homes. They could escalate directly to the most appropriate level of care, including the acute sector.

- **Comprehensive integrated assessment and early identification of patients at risk**, described as;
  Aimed at identifying all people at risk (the frail and pre-frail), using tools such as the Devon predictive score or electronic frailty score. Assessment and planning would be undertaken by trained staff who will work with Community Connectors. A plan would be developed with people and their carers to support people to remain well and retain their independence. Connectors would link with voluntary groups and work with social prescribing.

The anticipated financial savings from the reduction in beds is around £6m of which at least 20% (£1.2m) will be reinvested through the deployment of staff into place based care rather than community hospital roles and is expected to provide care to circa 60% more patients than currently.

The CCG team described the success to date of closing community beds, the majority of which were in its North Devon locality. 291 beds were reduced to 175 between October 2013 and October 2015 and five units closed (with Ottery St Mary due to close). £7.6 million a year has been saved through these closures with £1.0 million reinvested in staff working in the community. Data from North Devon was used to demonstrate that the new model of care has not impacted local non-elective admissions, average length of stay or bed days and GPs reported no change in workload.

The presentation also detailed the clinical engagement and leadership to date behind the proposals and how its preferred option was arrived at by its clinical cabinet. Development of the proposal has been led by the New Models of Care (NMoC) Group, a sub group of the Success Regime's Clinical Cabinet. Over 50 clinicians have participated in the work of the Clinical Cabinet and NMoC sub group. Fifteen possible options were developed by the NMoC, four of which emerged as viable based on the evaluation framework it developed. The Clinical Cabinet approved four options for recommendation to the Programme Delivery Executive Group which then asked for more analysis so it could identify a preferred option. The CCG team reported that the Clinical Cabinet had agreed Tiverton as its fixed site PFI hospital (32 beds) with Seaton (24 beds) and Exmouth (16 beds) as its preferred option. The CCG is consulting on whether Seaton or Sidmouth should be the 24 bedded site and Exeter (Whipton) or Exmouth the 16 bedded site.

6 Review Panel Discussion

Following the NEW Devon CCG presentation, the clinical panel asked the CCG team further questions as part of a rich and engaged discussion around the proposed model, clarifying detail, further work planned and potential pitfalls. The CCG team then left and the review panel held a further meeting to discuss the proposals and agree its recommendations.

The panel recognised that the CCG is working at pace and under pressure. It also noted that the clinical review process as part of the wider NHS England assurance framework is new to CCGs and Senates and that some pragmatism is required around what information should reasonably be

available prior to going out to public consultation which is when the senate is asked to review the strength of the clinical basis for the proposals. A huge amount of documentation was sent out to the panel, some of which was out of date by the time the panel convened to conduct the review. For future reviews it was proposed that CCGs complete a template to ensure its proposals are fully but succinctly described to the review panel in a timely way.

The Senate agreed that, in principle, it supports the proposals and concurs that the current historic model is not in keeping with the needs of today's population and understands that community bed closures should be able to trigger a beneficial programme of work. Good clinical engagement and knowledge was demonstrated at the review panel meeting. Additionally the support from the acute trusts and their role in leading workforce engagement was commended.

The panel felt that there was possible over-reliance on North Devon as a flagship model without sufficient information about the patients being supported in the community there. For example the population in East Devon is significantly older than in north.

The panel also advised caution not to over-sell the impact these proposals in East Devon will have on acute care beds and delayed discharges despite the audit showing 500-600 patients as medically fit to leave hospital. The CCG's business case is not predicated on an impact on acute bed based care at this point and it is important not to confuse the case for change to close the community beds in the East with having a direct impact on acute delayed discharges. The panel noted that the bed closures would only affect a small number of these patients and that the changes to community staffing and place based care need to be activated at the same time as the bed closures to impact on acute discharges.

The analysis offered by the CCG that closing 70 beds means adding 70 patients to an existing 5000 community nurse caseload, in turn only adding 1.5 patients to each practice's community nurse caseload resonated with the panel. However, the panel felt that further information about the current workings of community care and the CCG's community assets needed to be laid out.

Some apparent disconnects that need to be addressed were also noted by the panel. This included a backdrop of local cuts being proposed to social care packages at the same time as the CCG developing its place based care, and mental health provision in the community which would only come at a later stage once acute sector savings had been made.

The concept of replacing beds with community-based services was considered sound but the panel was unanimous in wanting to see more detail about the services that will replace these beds and greater information about the execution of the plans. In particular the panel was concerned about the lack of detail around workforce and social care.

The panel discussed the potential issues around making a currently hospital-based workforce mobile and whether staff will be trained before or after beds are closed. The panel felt there was not enough evidence that the ageing workforce can deliver the model and warned that the safeguarding of staff in homes and the community as well as their own travel times should be considered fully. These are not concerns that should halt public consultation but they were deemed important to address well in advance of closing any beds. Following the review, the CCG described that each member of staff will need a personalised assessment of learning needs as staff are identified for new roles and that following this specific training plans will be developed. This training having been completed should form one of the operational conditions for a safe implementation.

7 Key Lines of Enquiry

A set of key questions for the panel to explore within the clinical review was shared in advance with both the panel and the CCG. In addition to this the panel put forward their own questions following review of their pre-reading packs. This checklist of potential questions or lines of enquiry to help guide discussion was developed from a national guidance document on conducting senate reviews (appendix 7). As part of the panel's process to develop its recommendations for the CCG it went through the checklist and confirmed the questions had been covered in the wider discussion.

Whilst the proposal was refined in the weeks before the final panel meeting, following the session on 15th September the panel were clear regarding the model proposed for community beds in East Devon and understood the rationale behind this approach. As identified in the recommendations the proposals were considered well thought through at this point in the process but that there are areas that need strengthening.

The programme management arrangements were felt to be robust, with strong clinical leadership behind them. The proposals are underpinned by as much evidence base as there currently is in this area supported by national policy and emergent evidence. The panel did reference international evidence around the rise in the cost of homecare that should be considered in the context of such proposals being the direction of travel for many healthcare economies. Local data from bed closures in North Devon is persuasive (acute admissions showed a 6% reduction, compared to a 9% increase across the rest of NEW Devon).

More detail to support the proposals and ensure they are robust is required throughout. It is understood that this will come at a later stage but this should be signed off by NHS England prior to implementation of bed closures. For example, how common conditions such as UTIs, falls and respiratory symptoms will be handled should be clarified. In particular the execution of the model needs to consider the workforce and social care arrangements to support it as well as mental health and the prevention agenda. The use of remaining community beds, outcome metrics and technological opportunities all need to be considered in more depth to provide assurance that the bed closures and place based care model will be successful and deliver real benefits to patients. It is this further detail that forms the nub of the review panel's recommendations. A clinical risk analysis is understood to be in governance documentation but the Senate has not seen this so cannot offer any assurance in this regard.

The panel felt that the proposals do have the potential to deliver benefits to a wide number of people and support better integration of services providing there is sufficient investment in community-based services and in the workforce to deliver these services. The skills required to care for patients in their own homes are different to those required for working in an acute or community hospital setting. Staff will also need access to patient records while out in the community to deliver joined up care and technology needs to be identified to support this. Issues such as mobile phone coverage in rural areas to support place based care do need to be considered. The proposals do appear to have analysed the issues of patient access although the panel would like to see more detail on where Rapid Response services will be based and more generally how you will make greater use of technology to bring services to patients. In terms of wider alignment with the

development of other health and care services the panel would have liked to see more detail on how proposals fit together with Urgent Care Centres and how they are located in the wider Devon STP plan.

8 Next Steps

The review panel advises that the recommendations laid out at the start of this report are implemented by NEW Devon CCG prior to the closure of its community hospital beds in its Eastern Locality, in particular arrangements regarding workforce. The panel suggests that a meeting with NHS England Assurance team is set to go over the CCG's response to the recommendations in advance of implementation and that the timeline for this and the outcome of this meeting with NHS England is fed back to the Clinical Senate.

The Senate understands that this proposal around community beds in the Eastern locality is the first stage in a wider programme of work as part of the Success Regime programme and linked to the Wider Devon STP. As a result the Senate welcomes early discussion around further stages of work to ascertain what if any clinical review is required.

9 Reporting Arrangements

The clinical review team will report to the Clinical Senate Council which will agree this final report and be accountable for the advice contained therein. The report will be shared with the CCG and NHS England Assurance Team. NEW Devon CCG will own the report and be responsible for any implementation of recommendations.

At the special request of NEW Devon CCG, the draft report will be sent to the CCG at the same time as it is shared with the review panel and senate council for comment in order that the key recommendations are available to the CCG Governing body on 28th September.

The final report will go to the following groups for sign off in October:

1) South West Clinical Senate Council
2) NEW Devon CCG Governing Body
3) NHS England Assurance Team

The final report will then also be shared with;

4) Devon Healthcare Trusts
5) South West CCGs
6) South West Clinical Senate
7) South West Citizens' Assembly

10 Appendices

Full appendices are available in a zip file from sarah.redka@nhs.net on request.

10.1 The Review Panel

The review panel comprised 16 members of the Clinical Senate Council representing broad and relevant expertise from across the South West. In recognition of the fact that the CCG required clinical review input rapidly, the Senate used an existing council meeting to run a review panel.

Name	Title	Organisation
Phil Yates	Panel Chair,	South West Clinical Senate
Marion Andrews-Evans	Executive Nurse	Gloucestershire
Mary Backhouse	GP	North Somerset CCG
Katie Cross*	Consultant General Surgeon	Northern Devon Healthcare Trust
Kevin Dixon	Citizen Representative	Citizens' Assembly
Sara Evans	Consultant Geriatrician	Royal United Hospitals Bath
Paul Eyers	Vascular Surgeon	Taunton & Somerset NHS Foundation Trust
David Halpin*	Consultant Physician	Royal Devon and Exeter Hospitals Trust
William Hubbard	Head of Medicine	Royal United Hospitals Bath
Joanna Kasznia-Brown	Consultant Radiologist	Taunton &Somerset NHS Foundation Trust
Debbie Stark	Public Health Consultant	Public Health England
Margaret Willcox	Director, Adult Social Care	Gloucestershire County Council
Paula Williams	Citizen Representative	Citizens' Assembly
Paul Winterbottom	Consultant Psychiatrist	2gether NHS Foundation Trust

*Declared a potential COI due to working in the NEW Devon CCG area. This was noted by the Chair but members were not excluded from discussions.

The NEW Devon CCG attendees were as follows:

Name	Title	Organisation
Jo Andrews	Principal	Carnall Farrar
Chris Bowman	Associate Medical Director of Community Hospital	North Devon District Hospital

File path:

Gilly Champion	Eastern Locality Board Member and Partner & Lead Partner Nurse GP Practice	NEW Devon CCG
Janet Fitzgerald	Director of Corporate Governance	NEW Devon CCG
Anthony Hemsley	Consultant Geriatrician	Royal Devon and Exeter Hospitals Trust
Phil Hughes	Medical Director	Success Regime
David Jenner	Eastern Locality Chair and CCG Board Member	NEW Devon CCG
Ros Wade	Head of Therapy	Royal Devon and Exeter Hospitals Trust
Em Wilkinson-Brice	Director of Nursing and Co-chair of NMoC	Royal Devon and Exeter Hospitals Trust
John Womersley	Northern Locality Chair and CCG Board Member	NEW Devon CCG

10.2 Timeline

The South West Clinical Senate team (Manager and Associate Director) originally met with NEW Devon CCG in early May 2016 to discuss the review. Subsequently the sense check described above was carried out and more information requested. Following the May meeting, Terms of Reference were developed in early June outlining the methodology, process and timeline for the review (see appendix 1) and upon CCG sign off in July, a clinical panel was convened. The Senate also commissioned a literature review and requested a pre-meet with CCG clinical leads. The CCG initially intended to go out to public consultation at the end of July and it was therefore proposed the Senate run a clinical review concurrently to consultation. This date later shifted and it was then requested that the Senate complete its review prior to the new consultation date.

The Senate team met to review the documentation submitted by the CCG describing its proposals on 10th May and fed back to the CCG at this point any issues it felt might be raised by the panel, which at this point were broadly the same as those highlighted in the sense check. The documentation was then sent out to the panel for pre-reading and to send back any comments which were subsequently shared with the CCG at the formal pre-meet.

Initial pre-reading sent to the panel included:

Wider Devon STP April submission
Phase 2a Draft Recommendations
Phase 2a Summary Slides for Senate
Draft PCBC V1.13
CCG Governing Body Meeting 28th July 2016
Case for Change Final Draft February 2016
Your Future Care Consultation Document July 2016
Phase 2a Summary Memo

The CCG has been working at pace since May and the proposal for this review was refined only to include the reduction of community hospital beds in the Eastern Locality.

The Senate team (Clinical Chair and Manager) then met with the CCG clinical team in a formal pre-meet on 6th September. The slide presentation from this meeting was subsequently shared with the review panel.

Final documents as follows were sent to the Senate Management Team on 12th September which it kept for reference if required but it was agreed not to send these new versions onto the panel at this late stage;

- Final Consultation Document
- Final Pre-consultation business case

At the 15th September Panel meeting the following were also tabled in addition to a presentation developed for that meeting;

- New Models of Care Implementation Governance V4
- John and Mary case study
- Quality and Equality Impact Assessment PCBC [1]

The formal panel review took place during the scheduled Senate council meeting on 15 September 2016 at which NEW Devon CCG was invited to present its proposals and respond to questions and observations by panel members.

The Senate agreed to submit a shortened draft report to the CCG by close of play on 21st September in time for their governing body papers deadline ahead of the governing body on 28th September. An external writer was brought in to help draft the report over the weekend following the panel meeting in order to accommodate the governing body papers deadline. As a result it has been agreed on this occasion to send the draft report to the CCG at the same time as it is sent to the review panel and full senate council for comment. The draft report will be available to the CCG governing body and finalised shortly after once sign off has been received as described below.

Early discussion	May 2016	Senate, CCG, NHSE Assurance Team
Draft ToR	June 2016	Senate Management (ED/PY)

Establishment of clinical review team	July 2016	Ellie Devine
Information gathering	July 2016	Ellie Devine and CCG
Review planning; identifying clinical leads, agree key lines of enquiry with Panel	July 2016	Phil Yates and Ellie Devine
Literature and data review	July 2016	Ellie Devine
Pre-meets with clinical leads	Early August 2016	Phil Yates and Ellie Devine
Meet with Delivery Team and clinicians – review meeting	August/Sept 2016	Phil Yates, Ellie Devine, review panel and providers
Panel meeting	15th September	Phil Yates, Ellie Devine, and review panel
Report Writing	16th-21st Sept	Ellie Devine/External writer
Draft to Panel for Comment	21st Sept	Panel
Draft report to Senate council (via email)	21st Sept	Senate Council
Draft report to CCG for comment	21st Sept	CCG
Sign off of final report	27th September	Senate Management Team

10.3 Terms of Reference

10.4 Review Panel conflicts of Interest submissions

10.5 Review Panel confidentiality declarations

10.6 Review Panel Biographies

10.7 Panel Checklist

10.8 Pre-meeting notes

10.9 Pre-reading

10.9.1 Wider Devon STP April submission

10.9.2 Phase 2a Draft Recommendations

10.9.3 Phase 2a Summary Slides

10.9.4 Draft PCBC v1.13

10.9.5 Draft Recommendations Report 18th March

10.9.6 CCG Governing Body Meeting 28th July

10.9.7 Your Future Care Consultation Document July 2016

10.9.8 Phase 2a Summary Memo

10.9.9 Case for Change Final Draft February

10.10 Literature Searches

10.11 CCG Slides for Panel 15th September

10.12 Pre Meet CCG Slides

10.13 Final Consultation Document

10.14 John and Mary Case Studies

10.15 New models of care Implementation Governance