

Stage Two Clinical Review Report

Clinical Review of South Devon and Torbay CCG Community Services Transformation

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14th October 2016

Final

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

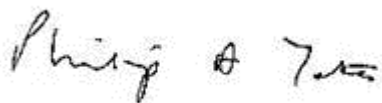
1 Executive Summary

1.1 Chair's Summary

This report has been produced by the South West Clinical Senate for South Devon and Torbay Clinical Commissioning Group (CCG) and provides recommendations following a clinical review panel that was convened on 22nd September 2016 to consider the CCG's proposals for community services transformation.

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. The Senate considers test 3, the evidence base for the clinical model as an independent clinical advice giving body. In this case, as requested by NHS England, the Clinical Senate agreed to conduct the clinical review concurrently to the public consultation which is running from 1st September 2016 to 23rd November so as not to delay the consultation and subsequent implementation.

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



Dr Phil Yates

Chair South West Clinical Senate

1.2 Recommendations

Overall Recommendation

The South West Clinical Senate Review panel supports South Devon and Torbay CCG's proposals for community services transformation. This includes an increase in place based care with the development of 3 clinical hubs and 7 health and wellbeing centres supporting the reduction from 7 to 3 community hospitals (closing 60 beds) and the closure of one further Minor Injuries Unit (MIU). The proposed model is in line with the policy direction set out by the 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 9.10).

The CCG team described a relatively sophisticated model that is already moving ahead, making investments prior to bed closures and with the intention to invest a significant amount of savings back into the system. The CCG are currently implementing the investment elements of the model of care but consulting on the wider model and closure of beds which will release funds to support the model year on year. The whole systems approach, that will benefit patients and is being led by a clinical team with the belief and enthusiasm required to deliver it received positive support from the panel. There was strong endorsement of a maturity in the system seen that doesn't necessarily exist elsewhere. The panel recognised the challenges of delivering any successful model of care across a rural location and the need for pragmatic solutions that can flex capacity.

The panel noted that the Integrated Care Organisation (ICO) has seen good integration since its inception in 2015 and commented that this model of care represents an excellent opportunity to invest in community services, building on several years of work on integrated care in the Torbay area and supporting hybrid roles.

Whilst the model and progress are supported, the panel did concur that given this is a large plan with many interdependencies, and that additional staff recruitment is already underway, there needs to be significant improvement in articulation of the clinical model. This should include the interdependencies with other services, and how the model will be flexed to meet the needs of people living in more rural areas. There particularly needed to be a clearer illustration of the model for delivery of urgent care and the relationship with primary care.

Whether GPs across the four localities are being sufficiently engaged and whether the proposed model will provide them with enough support was a key issue raised by the panel.

The clinical panel's overall comments and recommendations for the CCG to take into account in addition to its support for the model are as follows;

Comments and recommendations:

1. The CCG demonstrated through panel discussion that they are significantly ahead in thinking and action of that which was described via the evidence submitted and presentations. An opportunity is being missed to describe a wider and overall better model of care than in the current system.

It was clear that the CCG has made progress in delivering the new model of care and that there is robust clinical thinking behind it but this was not sufficiently evident in the submissions to the clinical panel. It is important to be able to clearly articulate the programme of work, the current status and overall timeline that is clearly already known via one or two succinct documents that go beyond communications designed for public consultation. This is recommended to support CCG planning and reporting on this model of care going forwards.

2. There is a risk of either excluding or increasing pressure on the GP workforce in the new model. The concept of 'wrap around' care for long term condition management and urgent care pathways that support the delivery of primary care needs to be clarified as do the mechanisms for supporting developed roles and the portfolios of GPs.
3. As the Devon wide Mental Health Partnership Trust is not part of the ICO, work programmes between the two organisations must be aligned with particular focus on elderly dementia and depression.
4. The model for Health and Wellbeing Co-ordinators and evidence from Cornwall needs to be used to ensure that the 'Every Contact Counts' philosophy is a meaningful one.
5. The clinical leadership model to support staff delivering place based and intermediate care across the community needs more work so that it does not rely on ad hoc relationships for quality and safety. A diagram to demonstrate the clinical leadership model of the workforce for the multidisciplinary team working is requested (to include how secondary consultants are linked in when required) and leadership and management training is recommended for clinical team leaders in the community.
6. More consideration of how the model will provide the flex required in the system over the summer period should be demonstrated.
7. That the Vanguard for urgent and emergency care guidance is implemented.
8. More evidence on the current model in the Coastal locality and outcomes to date would be helpful to support the community transformation work and demonstrate continuous learning.
9. The role of expanded primary care would merit further consideration as part of the Clinical Hub and Health and Wellbeing strategy by engaging relevant representative bodies (ie. LPC, LOC, GPs).
10. The CCG is encouraged to seek input from the NHS England Primary Care Project Board and the Devon Project Manager to ensure consideration of primary care sustainability and links beyond the organisational arrangements of the ICO as this model of care develops.
11. It is important to show that broader plans for Urgent and Emergency Care (UEC) redesign are shown to have been considered as part of the MIU closures. Clear working alongside the UEC network wasn't demonstrated.
12. Pressure testing of expected population growth and increases in visitor numbers to the region would help in articulating how increases in activity will be factored into services in the community as well as into primary and urgent care.

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 and that the clinical model is robust.

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 a preliminary meeting with the CCG's core clinical team 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 well thought-out as possible.

The South Devon and Torbay CCG proposal is to reduce from 7 to 4 community hospitals (closing 60 beds) and the closure of one further MIU, replaced by an increase in place based care, 4 clinical hubs and 7 health and wellbeing centres. The developments to non-bed based community care include an annual investment of £5.1m per year (taken from the projected £6.3m savings from closures). The CCG has been able to secure £3.9 in pump priming funding from the ICO and has already begun to recruit many of the additional staff required to implement its model.

The context for this change is set out below and describes how the quality of care for patients needs to be improved as well as providing the rationale for improving productivity.

3 Local Context

The NHS in South Devon and Torbay provides care and treatment to a population of 286,000 although this increases to 370,000 with the influx of tourists over the summer period. Around three million episodes of NHS care are delivered annually in South Devon and Torbay, a number forecast to rise significantly over the next decade. However, the CCG have described how at present in South Devon and Torbay, there are more community hospital beds than required.

South Devon and Torbay CCG is developing a model of care to transform community services as a result of both local and wider national pressures. In each of the CCG's localities there are also significant differences in life expectancy between the most deprived and least deprived areas; the numbers of people in the under-16 or over 85 age groups; and the number of emergency admissions.

The model of care has also been developed in response to an increased number of older people and with long-term conditions, flat and reducing finances and increasing requirements for delivery of NHS professional standards to provide high quality care. The new model of care has been developed over the past three years, since the CCG initiated public engagement discussions in 2013.

This is also set in the context of a new and developing integrated care organisation under South Devon NHS Foundation Trust which began acquisition of Torbay and Southern Devon Health and Care NHS Trust in 2014 under the “Transforming Community Services” programme. The new integrated care organisation, launched in October 2015, brings Torbay Hospital and local community-based health and social care services into a single provider Trust. The CCG ambition is to extend this integration to include a more joined up way of working with local voluntary and charitable organisations, and with partners in other public services such as mental health and children’s social care.

The CCG operates services through five localities, each led by local GPs: Coastal (Teignmouth and Dawlish), Moor to Sea (Ashburton, Buckfastleigh, Totnes and Dartmouth), Newton Abbot (includes Bovey Tracey and Chudleigh), Torquay, Paignton & Brixham.

Their coastal locality is not part of this transformation or review process as the CCG consulted for this locality regarding a further 2 community hospitals in 2015 and improvements are currently being implemented.

4 South Devon and Torbay CCG’s Proposal

The CCG team delivered a presentation at the stage two review panel meeting on 22nd September to complement the evidence pack already sent to the panel as pre-reading. The presentation is included in appendix 9.11 and the pre-reading in appendix 9.9.

The presentation described that the majority of services affected are all delivered by the Integrated Care Organisation, that the Coastal locality is excluded from this work and that the South Devon and Torbay area has high admissions to hospital with the current model no longer being affordable given the savings they have been asked to make. The CCG cited a projected financial gap of £142million by 2020. A range of acuity audits were carried out in 2010, 2011, 2012 and 2015 demonstrating that 25-30% of patients in beds would be medically fit to leave hospital, providing there were services elsewhere to support them in the community. Prior engagement work led by the CCG since 2013 has told them that patients want to be at home if they can be. The model proposed focuses on wellbeing, health and social care and community based specialist care.

In summary, the core changes proposed include:

- Closure of four out of 7 community hospitals for this consultation with bed closures as follows; Ashburton and Buckfastleigh (10 beds), Bovey Tracey (9 beds), Dartmouth (16 beds) and Paignton (28 beds). Totnes, Newton Abbott, Teignmouth, Brixham and Dawlish will remain open with up to 16 beds (with 2 nurses) in Totnes, Brixham and Dawlish and up to 60 (including 15 stroke beds) beds in Newton Abbot which is a PFI facility. 60 beds will close leaving 110 remaining. Some flex to provide intermediate beds was noted.
- Reduction of MIUs by closing Ashburton (currently suspended), Brixham, Dartmouth, (currently suspended) and Paignton. Three remaining MIUs would be co-located with community hospitals at Totnes, Newton Abbot and Dawlish (in coastal and out of scope for this review) would all open 8 am to 8 pm, seven days a week with diagnostic provision.

- Provision of improved community based out of hospital services through a clinical hub in each of the 4 localities. 3 of the clinical hubs will be in 3 of the 5 remaining community hospitals (Totnes, Newton Abbott and Brixham). The fourth Torquay hub will be a new purpose built dedicated children's clinical hub.
- 7 health and wellbeing centres within the main town areas. Linked to the locality clinical hub, these will be delivered from Ashburton/Buckfastleigh, Bovey Tracey/Chudleigh, Brixham, Dartmouth, Newton Abbot, Paignton, Totnes and Torquay. These will see community staff based locally and working alongside GPs, pharmacists and voluntary sector organisations to provide health and wellbeing services to the area.
- Community Services to be enhanced via the increased role for the voluntary sector with well-being co-ordinators in each locality; the introduction of a long term conditions service in each locality; a focus on prevention/self-care/early intervention; the development of a single point of contact and multi-agency teams in each locality; provision of pharmacy support in each locality; and the increase of 94 wte staff.

The CCG presentation described how the proposed model is built on a minimum of 7,000 contacts a year for nurses in an MIU, with safety being the main driver behind the MIU closures. 16 beds are the minimum in a community hospital, staffed by 2 registered nurses. With a £5m investment per year into community services, the programme is expected to save £1.4m year on year. The clinical team presenting did stress that even without the current pressurised financial climate, they would still want to introduce the proposed model of care.

The CCG confirmed the ICO is recruiting the equivalent of 94 additional full-time staff to help deliver community services in Torbay and South Devon. This includes nurses, physiotherapists, occupational therapists, locality pharmacists and new wellbeing co-ordinators, focusing this investment on intermediate care and reablement teams to support patients out of hospital and in the community.

The CCG's consultation will finish on 23rd October and the Jan/Feb 2017 board meeting will make decisions around next steps based on a paper produced by Healthwatch. This clinical senate report is expected to feed into this.

5 Review Panel Discussion

Following the South Devon and Torbay CCG presentation, the clinical panel asked the CCG team further questions as part of an engaged and constructive 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.

IT

The CCG described their digital roadmap as part of the Wider Devon STP including plans for primary care to share information with community services. Assistive technology is being explored, particularly teleconferencing to avoid travelling to outpatient appointments.

Health and Wellbeing Co-ordinators

The panel noted that the demographic projections for the area show a particularly high increase in people over 85 and the CCG team confirmed that they have been reviewing public health data by town, deprivation and disease prevalence to help plan services and consider access.

It was noted that Public Health colleagues are also being squeezed in terms of time and resource, and that there needs to be sufficient capacity retained in preventive services both to signpost and to provide direct support whether through the Council, NHS or voluntary agencies. £177k is being invested in health and wellbeing co-ordinators who are being recruited through the voluntary sector. These roles will focus on prevention and community based mapping to understand their community and voluntary sector assets has been carried out. The CCG described how they will seek to embed an 'every contact counts' philosophy across the community so that it becomes the business of all members of staff with screening and protection policies implemented to trigger wellbeing needs. There was some scepticism around how meaningful 'every contact counts' is in practice however the CCG cited the outcomes from the health and wellbeing co-ordinators in Newquay as evidence (appendix 9.9.5.1) to support the development of the co-ordinator roles and this was provided after the meeting.

The Health and Wellbeing centre in Teignmouth which is part of the Coastal locality work that is already underway was described (but not evidenced) as moving along well with development. The CCG confirmed they are starting phase one building works at Teignmouth Hospital with the Health and Wellbeing Centre due to be completed in mid-December 2016. The CCG is also currently advertising to recruit to community locality pharmacist posts to support the health and wellbeing teams. In addition to this the CCG referenced its medicines optimisation strategy which links to care being delivered in people's homes. The CCG also referenced (not evidenced to the panel) wider work that was ongoing with social care and housing services, the police and fire services to work to share community assets and develop a shared interest in supporting vulnerable members of society to ensure that looking after the community is not only the sacred domain of the NHS.

Clinical Hubs and Health and Wellbeing Teams

The panel asked for more information about how the clinical hubs and health and wellbeing teams would link together. The coastal clinical hub in Dawlish where there are both inpatient beds and specialist outpatient clinics and the health and wellbeing centre that has GP input at Teignmouth hospital were referenced. Beds, community teams, community matrons and discharge co-ordinators are already working together but relationships need to be formalised.

The Clinical Hubs and Health and Wellbeing Teams offer an opportunity to enhance the importance of Primary Care sustainability further. However a risk is also run that recruiting for example pharmacists into the clinical hubs could potentially duplicate or possibly undermine some of the care that would normally happen in community pharmacy or other existing parts of community care. Community pharmacy partnerships could potentially enable services such as discharge and transfer of care pathways. Work with pharmacists has been carried out behind the scenes and again this should be articulated in the detail around the model of care and its background.

Further granularity around the facilities that will be available at the health and wellbeing centres and in the community hospitals and clinical hubs is required. For example, for effective rehabilitation therapists will need access to a gym with parallel bars and miscellaneous equipment. This is particularly useful for in-patients but can also be very helpful in out-patient rehab.

Multi-Long Term Conditions Clinics

More information was requested around how multi long term condition clinics are expected to reduce outpatient attendances. The CCG clinical team were able to provide a much more detailed description of this vision than is demonstrated in the paperwork. Wellbeing coordinators will be used to pull patients out of hospital into intermediate level clinics and linking into specialist teams, specialist nurses, GPs and social care. Although the cohort of patients still needs to be identified the

clinic is expected to be both preventative and support patients who have numerous needs but don't need secondary care management. It would be helpful to include reassurance around what sort of GPs would staff these clinics, where the capacity will come from, and how they would be different to regular primary care clinics in further and more detailed iterations of the model of care.

Co-location of Services

The panel asked about the co-location of health and wellbeing services with GPs on the same premises. The CCG explained that there are progressive options they can explore around premises with the £5m investment they already have available. For example there is a possibility that an 80 bed nursing home with only 25 occupants may be available to lease as a health and wellbeing facility partnered with the care home. The panel noted that the overall plan is very large with lots of interdependencies and the risks this brings need to be well managed.

Mental Health

It was noted that the Devon Wide MHP Trust is not part of the ICO and that this should be considered given the considerable potential benefits to the wellbeing approach on mental health. The CCG confirmed that discussions had begun to align work programmes and that there may be some opportunities in the re-tendering for the Trust contract in 2018.

GP Interface

There has been one GP clinical lead per locality in post since the inception of the CCG to promote locality working between practices and locality-based commissioning. Locality clinical directors are being appointed to as new posts by the ICO and GPs are being asked to drive and develop the model.

The panel raised the concern that the proposed model could put additional strain on GPs who have overall responsibility for patients in an already pressurised primary care system. It was mentioned that when the integration model was first developed that some GPs felt excluded and this needs to be different moving forward. The CCG clinical team discussed that creating time for GPs was a core principle in their model which hinges on enhanced intermediate care with the GP at the centre and investment to support this. There was some discussion of the potential risk of GPs under the new MCP contracts setting up their own Accountable Care Organisations should they not be fully brought into the new model of care.

Minor Injuries Units (MIUs)

The group discussed the decision around the number and location of the 3 MIUs and the fact that there won't be an MIU anywhere in the bay south of Dawlish despite the annual influx of tourists to that part of the region. There will be a health and wellbeing centre in Dartmouth where the MIU is closing and the CCG described the need to recruit the right practitioner with the right skill set to deliver enhanced primary care in this location. Previously x-ray was available for 2 hrs 3 times a week and this will no longer be available in Dartmouth. The MIUs that have been closed and are closing have experienced rural location issues where they do not have sufficient attendances to maintain competence and expertise of staff. The CCG confirmed that all patients in the region should be able to access an MIU by car or public transport within 30 minutes and noted that in the south of the region patients are also very close to Plymouth if they need hospital or urgent care access.

Community Beds

The group discussed how the remaining community beds will be run and the nursing cover for them. A flexible model was described with co-ordinators placed in the acute trusts using the beds for discharge to assess as well there being some GP direct admits. It was confirmed that all community hospital beds will have access to x-ray. Newton Abbott also has ultrasound and may possibly have a CT scanner installed. An excellent bloods courier service was described running 6 times a day. The

CCG team confirmed that they have looked at the Royal College of Nursing evidence for caring for older people, the risks, co-morbidity and what professionals say is right for the nurse to patient staffing ratios in community hospitals, for which there is no mandated ratio. The group discussed that the nursing level need in a community hospital is different to that in an acute particularly as the skills of community teams are changing and that they will work on a basis of 2 registered nurses to 16 patients but that this will be flexed up according to level of dependency. A 'live working week' was conducted in 2013 and 2016 and dependency scoring is carried out twice a day.

Workforce

Whether all the patients in the community system can be managed by a decreasing workforce was queried. Currently there is a 12% staff turnover rate but there will be an impact when the impending retirement cohort hits. This natural movement however is expected to allow staff to move rather than needing to make any redundancies in the future. The panel noted that it was useful that recruitment and retention figures in the community are being looked at and that any failing practice issues are being monitored and picked up.

The CCG informed the panel that they are currently recruiting to the additional roles needed for each locality. 90% of the additional staff for enhanced intermediate care have been recruited to and will be starting in October. Out of hours and reablement focused skill-sets are being increased. The only area that has seen difficulty recruiting to is band 6 physiotherapists. Wellbeing co-ordinators have been recruited and approximately two fifths of the multi long term conditions staff have been recruited. The medical leadership roles for each of the localities have had interviews and job offers. The panel asked about the shift to use of staff in bands 1 and 2 evidenced in the ICO business case workforce graphs and how easy it is for these staff to shift to mobile working. There has been an 8% domiciliary pay increase bringing pay in line with the living wage which also includes travel time as paid for.

The panel asked about the clinical leadership for the community workforce and how supervision, team development and standard setting would work. A bespoke leadership programme was referenced but not evidenced. The team informed the panel that each profession will have a head and that there will be an overall multi-professional head to ensure ownership and the development of trained and skilled teams. Engagement with social care leaders is already present through joint appointments as part of the ICO. A tender is also being developed for a personal care lead provider.

6 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 (appendix 9.7). In addition to this the panel put forward their own questions following review of the evidence. 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 9.13). 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.

The panel noted that there has been a long history of collaboration that has led to the development of these proposals. The model is very similar to community transformation elsewhere in the country but South Devon and Torbay CCG are much further ahead than other CCGs as their acute and community integration structure is already more advanced.

The panel concurred that the proposals are well thought through but that the documents provided to the panel don't tell the full story, particularly when much of the recruitment for the additional staff through investment already secured is underway. The panel considered that while the CCG team leading the work behind the proposals were well sighted on the vision and its detail for implementation, much of which was being progressed, that the documented detail to support proposals is spread over a huge amount of documentation (as evidenced in the appendices to this report), much of it developed for consultation rather than programme management purposes. The programme management arrangements aren't clearly articulated but the work programme appears to be moving along at pace with a well engaged and informed core clinical team.

The proposals are underpinned by as much evidence as there is in this area and the direction of travel is clear with the case for change well illustrated. Overall the panel agreed that they support the proposals and believe they will deliver real benefit to patients. The panel expressed confidence in the overall model and the work already begun to invest in community services. The panel did note the potential financial risk in undertaking staff recruitment prior to the outcome of the consultation and decisions around service closures. This overall confidence would be strengthened by more succinct detail outlining the model of care in terms of workforce, recruitment, time line, activity and demand for different services, interdependencies, location of services etc. The panel commended the whole systems approach and overall alignment and integration with other parts of the system, building on the ICO and Torbay model. The panel felt that primary care leadership could be strengthened but the role of the ICO is very robust, has a clear focus and demonstrates medical and nursing teams working together. There was also some concern about the sustainability of urgent care and links to the vanguard work. It was noted however that some issues around recruitment and urgent care are nationwide problems and that what is being proposed is overall a progressive model.

7 Next Steps

The Senate agreed that it endorses the model of care proposed by South Devon and Torbay CCG and concurs that the current historic model is not in keeping with the needs of today's population. Good clinical engagement and knowledge was demonstrated at the review panel meeting.

The clinical review panel outlined some recommendations around documentation and primary care engagement amongst others, which it believes will strengthen the model of care and its implementation for the CCG to respond to. The Senate suggests a follow up brief is provided by the CCG in November once its consultation period is over and that this is shared with the assurance team.

8 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. South Devon and Torbay CCG will own the report and be responsible for any implementation of recommendations.

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

- 1) South West Clinical Senate Council
- 2) South Devon and Torbay CCG

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

9 Appendices

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

9.1 The Review Panel

The review panel comprised 12 members representing broad and relevant expertise from across the South West. The panel was drawn from the Senate Council, Senate Assembly and also brought in a couple of new members recommended by the council for this particular review. All members were fully briefed about their role as part of the review process to include review panel member packs, pre-reading and a pre-meet.

Name	Title/Organisation	Role
Phil Yates	South West Clinical Senate Chair	Panel Chair
Mary Backhouse	GP and Chief Clinical Officer, North Somerset CCG	Panel member - GP
Joanna Bates	Clinical Development Officer, SWAST	Panel member - Urgent Care
Bruce Laurence	Director of Public Health, Bath and North East Somerset Council	Panel member – Public Health Consultant
Stephen Chandler	Director of Adult Social Services, Lead Commissioner Adults and Health, Somerset County Council	Panel member – Social Care
Sara Evans	Consultant Geriatrician, RUH Bath	Panel member - Care of the Elderly
Michael Lennox	Chief Officer Somerset LPC	Panel member - Pharmacy
Carolyn Nation	Deputy Head Countywide Division, SOMPAR	Panel member - AHP
Joanna Parker	Citizens' Assembly and Healthwatch South Gloucestershire member	Panel member – Patient/Citizen Representative
Andrew Seymour*	Chair, Gloucestershire CCG	Panel member – Commissioner
Lucy Watson	Director of Quality, Safety and Governance, and Caldicott Guardian, Somerset CCG	Panel member – Community Nurse
Paul Winterbottom	Clinical Psychiatrist, 2gether NHS Foundation Trust	Panel member – Mental Health

*Declared a potential COI which was noted by the Chair but did not exclude the member from discussions.

The South Devon and Torbay CCG attendees were as follows:

Name	Title, organisation	Role
Dawn Butler	Assistant Director, Strategy and Improvement, Torbay and South Devon NHS Foundation Trust	Trust representative
Dr Rob Dyer	Medical Director, Torbay and South Devon NHS Foundation Trust	Trust representative
David Greenwell	Clinical Lead for Integration, South Devon and Torbay CCG	Clinical Lead from CCG
Shelly Machin	Divisional Manager, Torbay and South Devon NHS Foundation Trust	Trust representative
Rebecca Foweraker	Head of Commissioning and Integration, South Devon and Torbay CCG	CCG representative
Simon Tapley	Director of Commissioning and Transformation, South Devon and Torbay CCG	CCG sponsor
Jenny Turner	Locality Commissioning Manager, South Devon and Torbay CCG	CCG representative
Jane Viner	Director of Nursing, Torbay and South Devon NHS Foundation Trust	Trust Representative

9.2 Timeline

The South West Clinical Senate team originally met with South Devon and Torbay Devon CCG in April 2016 to discuss the review and following this, agreement was sought from NHSE assurance that a review could be run concurrently to consultation. The Terms of Reference were then developed in early June outlining the methodology, process and timeline for the review (see appendix 1) and upon CCG sign off in July, the clinical panel was convened. The Senate also commissioned a literature review and requested a pre-meet with CCG clinical leads.

The Senate team met to review the documentation submitted by the CCG describing its proposals on 11th May and fed back to the CCG at this point any issues it felt might be raised by the panel. 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.

The Senate team (Clinical Chair and Manager) then met with the CCG's core clinical team in a formal pre-meet on 30th August 2016. The slide presentation from this meeting was subsequently shared with the panel along with some further information for pre-reading.

The Senate Management Team were also sent further documentation on 20th September 2016. It was agreed that due to the late stage of receipt of these documents that they would not be circulated to the panel and the CCG would highlight of specific documents of relevance at the panel review meeting on 22nd September 2016.

Early discussion	March - May 2016	Senate, CCG, NHSE Assurance Team
Draft ToR	9 th June 2016	Senate Management
Share ToR with CCG for comment	14 th June 2016	Senate and South Devon and Torbay CCG/NHSE
Finalise and sign of ToR	21 st June 2016	Senate and South Devon and Torbay CCG
Establishment of clinical review team	By early July 2016	Ellie Devine
Information gathering	By end July 2016	Ellie Devine and CCG
Review planning; identifying clinical leads, notification of site visits, agree key lines of enquiry with Panel	By end of July 2016	Phil Yates and Ellie Devine
Literature and data review	August 2016	Ellie Devine
Pre-meets with clinical leads	30 th August 2016	Ellie Devine and CCG
Panel review meeting	22 nd September 2016	Ellie Devine and review panel
Report Writing	Week of 26 th September 2016	Ellie Devine
Draft to Panel for Comment	29 th September 2016	Panel
Draft report to Senate council	29 th September 2016	Senate Council
Draft report to CCG	Week of 3 rd October 2016	CCG
Sign off of final report	Week of 10 th October 2016	Senate Management Team

9.3 Terms of Reference

9.4 Review Panel conflicts of Interest submissions

9.5 Review Panel confidentiality declarations

9.6 Review Panel Biographies

9.7 Panel Checklist

9.8 Pre-meeting notes

9.9 Pre-reading

9.9.1 Initial pre-reading sent to the panel on 11th August 2016

- 9.9.1.1 *Draft option rational v3***
- 9.9.1.2 *Draft population paper v4***
- 9.9.1.3 *Draft stakeholder engagement and feedback v2.2***
- 9.9.1.4 *Option development overall***
- 9.9.1.5 *Stakeholder briefing overall summary 15.3.16***
- 9.9.1.6 *Consultation document 3.8.16***
- 9.9.1.7 *Draft clinical case for change v4***
- 9.9.1.8 *Draft current use of health services paper v7***
- 9.9.1.9 *Draft financial paper v3***
- 9.9.1.10 *SW Senate clinical review ToR final 14.6.16***

9.9.2 Pre-reading sent on 14th September 2016

- 9.9.2.1 *ICO full business case Feb 12 final***
- 9.9.2.2 *Newton Abbott summary final 23.8.16***
- 9.9.2.3 *Paignton and Brixton summary final 23.8.16***
- 9.9.2.4 *Torquay summary final 23.8.16***
- 9.9.2.5 *Moor to Sea summary final 23.8.16***
- 9.9.2.6 *Consultation document interactive spreads***
- 9.9.2.7 *Clinical review checklist***
- 9.9.2.8 *IRP learning from reviews***
- 9.9.2.9 *Full EIA v7 April 2016 ICO***
- 9.9.2.10 *Integrated workforce strategy update final 29.9.16***
- 9.9.2.11 *Possible configurations***
- 9.9.2.12 *Evidence base community hospitals***

9.9.3 Documentation sent to Senate Team on 22nd September

- 9.9.3.1 IC TS 16.03.15 approved**
- 9.9.3.2 Impact assessment v4.0 Moor to Sea 19.09.16**
- 9.9.3.3 Senate presentation**
- 9.9.3.4 Checklist of outstanding evidence**
- 9.9.3.5 16.05.04 TSDFT board of directors minutes public**
- 9.9.3.6 Appendix A integrated workforce strategy update final 29.9.10**
- 9.9.3.7 Buildings PDF**
- 9.9.3.8 Clinical case for change support document**
- 9.9.3.9 Community medical cover for South Devon**
- 9.9.3.10 Consultation locality summary M2S**
- 9.9.3.11 Copy of wellbeing prevention self care perf matrix v3.1**
- 9.9.3.12 GB & CSTG meeting summary evidencing clinical leadership and decision making**
- 9.9.3.13 Governing body minutes 28.4.16**
- 9.9.3.14 Locality CD job description v5**
- 9.9.3.15 Main consultation document**
- 9.9.3.16 Notes from locality commissioning group meetings**
- 9.9.3.17 Notes from locality leads and CCN meetings**
- 9.9.3.18 Options rationale support document**
- 9.9.3.19 Prevention well being and self care draft 3**
- 9.9.3.20 16.06 STP June submission final (1)**
- 9.9.3.21 SPG RPT work with the voluntary sector community groups v5**
- 9.9.3.22 ToR South Devon development board draft 2**

9.9.4 Documentation tabled for the Senate Team on 22nd September Panel meeting

- 9.9.4.1 Locality Clinical Director Job Description
- 9.9.4.2 Staff Engagement Update
- 9.9.4.3 Tabled Summaries of minutes from key meetings (paper)
- 9.9.4.4 Prevention Wellbeing and Self-Care Board TOR
- 9.9.4.5 Prevention Wellbeing and Self Care Matrix v4
- 9.9.4.6 Prevention, Wellbeing and Self-Care: A new approach
- 9.9.4.7 30th June STP Submission
- 9.9.4.8 Locality Plans
- 9.9.4.9 Moor to Sea EQUIA

9.9.5 Documentation sent following the review

- 9.9.5.1 Wellbeing coordination journey so far (sent post review as 'Newquay Evidence')

9.10 Literature Searches

9.11 CCG Slides for Panel 22nd September

9.12 Pre Meet CCG Slides

9.13 West Midlands Checklist