A Good Practice Guide: The Roles of the Clinical Senates (2016 onwards)

1. Introduction

Clinical Senates were set up in April 2013 following the Future Forum\textsuperscript{1} consultation on the implementation of the Health and Social Care Act (2012). The Future Forum recommended that “multi-speciality Clinical Senates should be established to provide strategic advice to local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board.” The Clinical Senates bring together expert clinicians and patient representatives to alert and advise commissioners on topics and to provide clinical assurance on proposals for significant changes to services for patients. The authority of the views expressed by Clinical Senates derives from the clinical expertise of the members, which ranges from Public Health advice to insights gained from specialist clinical practitioners and local patients, its impartiality and its independence. Above all, Senates have a role in providing an informed voice representing the needs of patients and the of wider population.

The primary purposes of the Clinical Senate as set out in the National Operating Model are to:

- Provide advice to inform NHS England’s service change assurance process
- Support health and social care systems to improve health outcomes of their local communities by providing impartial and evidence-based clinical advice to commissioners and provider on major service changes and transformation, enabling progress towards the broad vision set out in the 5YFV.

\textsuperscript{1} The ‘Future Forum’ was set up as an independent group in order to ‘pause, listen and reflect’ on the content of the Health and Social Care Bill the Future Forum made a series of recommendations. NHS Future Forum “Summary Report on proposed changes to the NHS” Page 11 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213748/dh_12754 0.pdf
- Engage a wide range of health and care professionals, with patients and the public, so that advice to support development of the health and social care system draws on a breadth of knowledge, expertise and leadership.
- Maintain a broad, strategic overview of the totality of healthcare across a particular geographical area and awareness of emerging issues to ensure that advice to support strategic planning, change and improvement is provided in this context.

Members of the Clinical Senate Council are expected to maintain an objective and independent view and declare conflicts of interest and follow processes according to the Nolan principles. While they are not statutory bodies, Clinical Senates are required to act in an open and impartial manner.

In April 2014, Clinical Senates were asked to take on the assessment of the clinical case for service reconfigurations which had previously been the remit of the National Clinical Assessment Team under the leadership of Dr Chris Clough. The Operating Framework for Senates was subsequently refreshed. This role has since been emphasised in subsequent national guidance on the reconfiguration of clinical services. The current guidance on planning and delivering service change identifies a role for the clinical senate in informing the NHS England assurance process prior to wider public consultation.

This is role may be further complicated by the fact that when local commissioning consortia ask for ‘strategic advice’ from the Clinical Senate, as independent legal entities they may want the ‘strategic advice’ to include some form of clinical assurance.

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3 Planning and delivering service changes for patients, NHS England December 2013

While there is not an absolute distinction between the provision of advice to local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board and the assurance-related work of the Clinical Senates, as the role of Clinical Senates in NHS England’s assurance processes is also advisory, it is important to be aware of the relative standing of advice and assurance and the potential pitfalls involved in the provision of these forms of clinical input to the design and commissioning of health services.

In the judicial review of the Greater Manchester Healthier Together plans, Mr Justice Dove examined both the generic advice of the South East Senate on interdependencies of clinical services and the assurance advice of the four Senates in the North of England. The nature of the advisory process, the assessment of the clinical case as part of the assurance process and the initial judicial view of the role of the Senates all indicate the importance of distinguishing between these roles.

2. Potential Conflicts and Dangers in Advisory Roles

The Clinical Senate may provide advice on how health services might be improved or an assessment as to whether the clinical case for change of health services (which is presented for assurance) benefits the patient. The danger is that there may be a perception that any assurance of a proposal on which the Clinical Senate has given prior advice may be influenced by that prior advice, which may have been given when the full facts may not have been available to the Clinical Senate.

There is also a danger that it may be perceived that any assurance of a proposal on which the Clinical Senate has given prior advice may have been influenced by the acceptance or rejection of the previous advice by commissioners or providers.

4 Keep Wythenshawe Special Limited Vs NHS Central Manchester CCG and Others. Neutral Citation Number: [2016] EWHC 17 (Admin) Case No: CO/4920/2015
Such views may be held privately by key individuals or may be a public perception, either of which may damage the credibility of the Clinical Senate and of its processes.

It must be acknowledged that the Clinical Senate or its membership may be subject to unconscious bias due to the influence of its intellectual and emotional investment in advising on the initial design of proposals that subsequently come to it for assurance.

For these reasons, we have explored these two functions of the Clinical Senates, assessed the potential for conflict between these roles and proposed guidance to ensure that the perceived and actual integrity of the Clinical Senates is preserved, without depriving commissioners of the benefits of these two independent but linked processes. We are aware of the importance of not restricting interactions with the Clinical Senate and thereby depriving the health economy of the full benefits of interaction with Clinical Senates.

While we have endeavoured to separate these two roles, it must be recognised that there may also be an advisory element in recommendations related to assurance and that the assurance process may lead to the identification of a need for further advice at a later time.

Engagement with the Clinical Senate, whether in the form of advice or as part of the NHS England assurance process, which may be either prior to or after public consultation, may enrich and enhance the overall clinical assurance of a proposal from the perspective of local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board.

The conjunction of advisory and assurance functions is not unique to the role of Clinical Senates. A parallel may be found where these two roles are commonly delivered by the same management consultancy in the commercial world. It has
been recognised that there is a need to carefully avoid conflicts of interest when such companies provide both internal audit and consultancy services (HM Treasury)\(^5\) while ensuring that the benefits of the synergies between these two related activities are realised.

3. Advisory Roles
Since their foundation, Clinical Networks have always offered improvement advice, in the form of best practice recommendations. Since April 2013, Operational Delivery Networks have performed a similar function in relation to their areas of specialist interest and expertise.

More recently, following a review of the centrally funded improvement leadership and development functions by NHS England \(^6\), clinical networks have taken on an additional role in identifying possible actions to be taken to mitigate service-delivery weaknesses identified in the course of assurance work. Clinical Directors from the Wessex Clinical Networks are members of the Senate Council, as are others who support or have supported clinical networks in the past.

Since its inception in April 2013, the Wessex Clinical Senate Council has also offered advice, in the form of best practice recommendations arising from its horizon scanning activity, e.g. on mental health service provision, or responding directly to requests for advice from commissioners, such as on the provision of vascular surgery services.

The Clinical Senate may also undertake analysis or evaluation of significant system developments (in partnership with the clinical networks) to help ensure that best

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\(^{5}\) HM Treasury Good Practice Guidance: The consultancy role of internal audit July 2010

practice recommendations are built into new clinical systems or pathways at the time of their development. Such analysis or evaluation, focussed on the benefit to patients and the wider population, may be very useful to CCGs in preparation for public consultation. However, this is advice to the commissioners and is not part of a formal assurance process.

Managers and clinicians increasingly recognise the value of the Clinical Senate Council’s systematic, disciplined and independent approach to areas of clinical best practice, patient and population benefit, clinical governance, strategic planning, and the mitigation and management of clinical risk. This may results in the Clinical Senate Council being called upon increasingly by local commissioning consortia, health and wellbeing boards, vanguards and Sustainability and Transformation Plan (STP) leads to advise on such issues in a consultancy role.

Senate Council membership includes senior clinicians who have particular skills in the understanding of clinical risk and the development of appropriate mitigation and management strategies to constrain these risks regardless of whether they are presented immediately or forecast in the short or long term. These skills can assist local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads to design a health and social care economy to be economic, efficient and effective in its approach to service change and the management of clinical risk.

However, these potential ‘clients’ of the Clinical Senate’s ‘consultancy’ may not see any benefit in inviting the Clinical Senate Council in to ‘mark their work’ or to ‘assess their readiness for an assurance review’. Any Senate report on what could have been done better or on alternative approaches that might have been used may not been seen as helpful once the project plan is completed and submitted to the assurance process with NHS England. For these reasons, early engagement with the Clinical Senate and an iterative advice process is likely to yield most benefit.
Similarly these potential ‘clients’ may want Clinical Senate Council advice in “emergency situations”, for example, following a major operational or commissioning failure or identification of an exposure to major risk. It is important that the Clinical Senate Council should plan to make appropriate resources available to deliver the intended advice service as part of its business planning process.

3. Assurance Role

Clinical Senates may be asked to review a service change proposal to provide assurance against the clinical evidence test prior to public consultation. The scale of the service change proposals under consideration will determine the extent of assurance required. The terms of reference will be agreed by the commissioning organisations and the review should cover all of the options which are being consulted upon.

The outputs from the Clinical Senates are the property of the commissioning organisations and should not be published or shared without their express permission. It is NHS England’s expectation that reports which inform the assurance process should be published at the time of public consultation.

The differences between improvement (non-assurance) advice and advice on assurance include the following:

1. The role of the Clinical Senate in assurance involves giving advice to a third party, NHS England, about the actions proposed by CCGs. This advice will come into the public domain as part of the public consultation process.

2. The assurance role may involve assessing proposed services against national standards and benchmarks and the public reporting of the outcome of such comparisons.

3. Assurance advice is published at the time of consultation on the proposed changes.
4. Improvement advice to local commissioners or wider systems is given to the requesters in a binary interaction, without reporting to a third party, although this will enter the public domain via the minutes of the Senate Council.

5. In order to be categorised as “assurance”, advice has to be provided by the Clinical Senate Council in accordance with the nationally agreed Clinical Senate Review Process Guidance Notes (August 2014). Assurance advice is usually based on a report from an independent review team, which examines the case for change and reports to the Clinical Senate Council.

6. For improvement advice, the Senate can draw on patients, clinicians, health and social care professionals on its database who have the relevant skills and expertise.

The *Good Practice Guide* offers support in the planning and delivery of a Clinical Senate improvement advice service in parallel with the assurance work plan. It is in five sections that explore:

- Linking improvement advice to the delivery of advice for assurance.
- The nature of the improvement and assurance advice services.
- Planning for delivery of improvement and assurance advice services.
- Professional conduct of improvement and assurance advice assignments and issues of independence/objectivity.
- How the Clinical Senate Council resources can be scaled up to meet potential demand.

5. The Relationship between Advice for Improvement and that for Assurance

Work on the preparation of advice on health and service improvement can add to the Clinical Senate Council’s knowledge base, allow for the accumulation of evidence, including the forecasting and mitigation of risks, assessment of patient benefit, modelling the impact of significant service change and clinical governance. This
process can make a contribution to the overall Clinical Senate Council view of a proposal that comes for assurance and allow it to better assess the likelihood of the success of any service reconfiguration in the health and social care economy.

Improvement advice activities may arise from assurance assignments when the conclusion of the assurance assignment is that there are significant risk and operational or strategic issues still to be resolved (i.e. – solutions need to be developed to problems identified by the assurance report). Conversely, improvement advice activities that arise at local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads request promote the Senate Council’s knowledge and understanding of the whole of risk, strategic and service planning, improvement and clinical governance capabilities and capacity in the organisation and consequently make a contribution to the overall assurance that is delivered by the Senate Council.

The preparation of advice on service improvement work may be carried out at the request of local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads. Where this happens it may be necessary, where later assurance may be required, to contextualise the improvement advice assignment in a ‘terms of reference’ document. This is important so that the incorporation of advice into a subsequent assurance report does not lead to inappropriate distortion of the materiality of the findings and to impairment of the credibility of the Clinical Senate’s role in the two processes.

This is particularly important if the criteria that are used for formulation of improvement advice are not be the same as those used for identification of advice for assurance assignments. The findings of the Clinical Senate Council should be put into context at the start and conclusion of any report, identifying whether the evidence was acquired and assessment made for advice on improvement or as advice for an assurance assignment. If a project is to involve a later assurance assignment an assessment should be made of the progress towards that objective.
It may be that local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads want the Clinical Senate Council to undertake a improvement advice assignment but seek some form of re-assurance that any findings will not be reported to the CCG governing body or NHSE or be included in any later assurance report. In such cases the assignment should be declined; the circumstances otherwise conflict the Clinical Senate Council in its assurance role and damage its credibility.

5. The Nature of the Improvement Advisory Service

The scope of the improvement advisory service that the Clinical Senate Council can offer is bounded by their skills set and clinical or professional expertise. This puts the focus clearly on evaluation against the available clinical evidence, identification of clinical risk and patient benefit, forecasting and mitigation of risk and clinical governance arrangements.

The improvement advisory service should not aim to deliver advice on topics or in areas in which the Clinical Senate Council Members or others recruited to assist do not have appropriate training and experience, nor should it supplant the clinical networks.

Assurance work tends to appraise the adequacy and effectiveness of planning intentions, including systems of risk management, sustainability and clinical governance. In contrast, improvement advice is likely to deal with situations where the business case or delivery framework is yet to be fully put in place. The advice offered by the Clinical Senate Council in its improvement role may include analysis of the clinical evidence base and proposing potential solutions to problems, perhaps including suggested improvement tools and service modelling exercises.

The Clinical Senate can offer a combination of clinical experience, patient and population perspectives and familiarity with strategic planning. Management consultancy companies are often not in apposition to easily provide this level of
insight but can complement the Clinical Senate’s advice in fields such as activity and financial analysis.

However it will be necessary to make clear in the agreed Terms of Reference for the assignment that the Senate Chair can only be accountable for ensuring due professional care is taken in developing advice which is later discussed and approved at a Clinical Senate Council meeting.

It is important that improvement advice is offered to support local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads in their work, not to be a substitute for their own efforts to address the issue in question. The Clinical Senate in its improvement role should offer them participative advice and support in their activities. The acceptance of advice given, of course, involves an acceptance of accountability for the consequences of implementing the advice; it may be beneficial to note this in the agreed Terms of Reference for the assignment.

Examples
There are a number of ways in which the Clinical Senate Council can undertake their improvement advisory role:

1. They may facilitate management activity. For example, if local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads want to hold a workshop or study day to brainstorm risks and possible solutions around a particular issue they will be well served to have a facilitator. Clinical Senate Council members can be well placed to undertake this role as their skills will help them to inspire and provoke management into effective identification and analysis of risks and possible solutions and to organise the results of their brainstorm into a structured view of what they are working with (specific training in facilitation skills is beneficial for Clinical Senate Council members who will undertake this sort of work). It is important that this role does not lead to the facilitator telling management what their
risks and planned actions are or should be as this would undermine management responsibility for their own activities.

2. The improvement role of the Clinical Senate Council in the facilitation of service change activity may also include advice in “emergency situations” as referred to above.

3. They may undertake an educational role. Clinical Senate Council members may be asked to support local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads by imparting appropriate risk, strategic or service planning and improvement skills and techniques so that managers are better equipped to undertake their own role effectively. This provides long-term added value by improving local skills in risk, strategic and service planning and improvement issues.

4. They may offer specific advice on particular risk, strategic and service planning and clinical improvement issues (including development of new systems or redevelopment of existing systems). This may be at any level of the organisation, ranging from the corporate risk register and clinical governance system to detailed improvements and review of particular and low level risks relating to specific individual activities. In this role it is important that the Clinical Senate Council member offers advice to local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads and does not undertake the task on behalf of, or as a substitute for them.

6. Planning for Delivery of the Improvement Advice Service

The Clinical Senate Council has a core membership and an “assembly” which is ‘virtual’ and consists of professionals and patients who have helped and who have volunteered to help in the future with external reviews. It also includes professionals and patients who have contributed to clinical network activities. Their contact details are stored on a stakeholder database which is currently being refreshed. Assembly membership goes beyond clinicians and includes public health, social care, health education, ‘expert’ patients and public representatives (who may have considerable experience of working with health in a planning capacity).
If local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads choose to place reliance on interim advice then this will be at their own risk in respect of due professional care and it should be made clear that the work is carried out outside of the core Clinical Senate Council remit. This would also be the case where they decide to disregard or halt the provision of advice.

It is self-evident that the consultancy and advisory service delivered by the Clinical Senate Council will require resources, which by definition are “scarce”. It is therefore necessary to plan how much resource will be made available for improvement advice and assurance advice work and how potential improvement advice and assurance advice activities will be prioritised in order to determine which can be undertaken and how much resource will be assigned to each.

The Wessex Clinical Senate has a small support team and a small budget. However, most of the patients, clinicians, health and social care professionals are released by their employing organisations free of charge to work with us (with a few exceptions where self-employment is the norm).

When the Clinical Senate Council intends to offer improvement advice services to meet demands indicated by local commissioning consortia, health and wellbeing boards, vanguards, providers and STP leads, a process will need to be designed to prioritise these demands, to decide which ones can be fulfilled, and how much resource will be assigned to particular assignments. As it is unlikely that it will be possible to meet every demand made, there will be a need to create a prioritisation process.

This might include:

a) Relating the particular demands to the risk and clinical priorities of the organisation – which demands are most significant in that respect?

b) Which demands appear to present the opportunity for the Clinical Senate Council to add maximum value?
c) Which demands emanate from parts of the organisation least equipped to resolve the issues from within their own resources and/or skills? Conversely, is the demand a request to undertake work that could equally well be undertaken by the organisation itself?

d) Which demands emanate from areas where assurance work is already planned? (If assurance work is already planned an element of improvement advice may be delivered by through the recommendations of the assurance report, or it may be possible to combine the improvement advice demand with the planned assurance work into a single assignment.)

e) Which demands appear to offer the opportunity for transferable “lessons to be learnt” to be generated which will benefit other parts of the organisation?

In planning for the delivery of improvement advice for any particular period, it should be borne in mind that new demands may emerge. For instance, an assurance assignment may indicate a high priority need to provide further support to management through improvement advice, or a change that could not be anticipated in the objectives or activities of the organisation may need to be responded to. Plans for the delivery of improvement advice services should aim to retain an appropriate level of contingency, and should be capable of being rearranged if appropriate.

7. Professional Conduct of Consultancy Services

The standard of work that is delivered in improvement advice services should be the same as that in assurance work. Due professional care, particularly in respect of objectivity and the obtaining of sufficient reliable evidence to support conclusions, must be maintained. This is important because the standard of work does not just potentially affect credibility in respect of the particular assignment but may impact upon the reputation of the Clinical Senate Council both in the organisation as a whole and as a profession.

A particular issue arises with independence. The Clinical Senate Council does not perform a management decision-making function; management are free to accept or
reject recommendations made as a result of Clinical Senate Council work. Therefore issues related to improvement advice activities should not impair the Clinical Senate Council’s independence or objectivity. It is acceptable for the Clinical Senate Council to provide improvement advice services relating to operations for which they had given advice for assurance. However, where such improvement advice work is important for future assurance, it remains important to preserve objectivity and the Clinical Senate Council will need to apply similar objectivity arrangements as for assurance work. This may require the recruitment of an external review team as outlined in the nationally agreed Clinical Senate Review Process Guidance Notes (August 2014).

Members of the Council and Assembly who have recent detailed improvement advice experience in the service area to be reviewed should not be assigned lead responsibility for the advice for assurance, but their knowledge and experience may be beneficial and could be utilised in an appropriate way for the benefit of the advice for assurance as long as the conflict of interest is recorded. If Senate Council members have potential impairments to independence or objectivity relating to proposed advice, particular attention should be paid to the Wessex Clinical Senate Council’s Business Standards and Conflict of Interest Policy. Steps must be taken to avoid or manage transparently and openly such conflicts of interest so that there is no real or perceived threat or impairment to independence in performing the improvement advisory role.

Relationships with local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board, other Clinical Senate Councils and other review bodies are especially important in improvement advice work. Improvement advice work relies on working in partnership with external organisations and Clinical Senate Council members engaged on improvement advice assignments should pay particular attention to building effective relationships with managers in those external organisations. The scope and objectives, timing, and reporting arrangements should

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7 Managing Conflicts of Interest and a Standards of Business Conduct policy
be agreed for improvement advice assignments in the same way as for assurance advice assignments in a ‘terms of reference’ document.

The ‘terms of reference’ document should make it clear that the Clinical Senate Council involvement is an improvement advisory role.

This means that for an improvement advice assignment:

a) There should be a detailed plan setting out the scope of what is to be reviewed.

b) The objectives should be defined at least in output terms, and ideally in outcome terms.

c) The exact role of the Senate Council member or members (e.g. – facilitator or member of a multidisciplinary working group) should be defined. [It should always be made clear that the Clinical Senate Council is not part of any sign off decision mechanism.]

d) Reporting formats should be defined (e.g. - will there be a specific report or will the Senate Council member(s) work contribute to a report generated by a multidisciplinary working group. [see also below])

e) Timing issues should be defined in detail, including the amount of staff days allocated and targets in terms of elapsed time.

It is important that the work of the Senate Council member(s) is appropriately documented and recorded and that the same standards of evidence are applied to improvement advice work as are applied to assurance advice work. Evidence should be sufficient, relevant and reliable to sustain the conclusions reached. In this respect one valuable role that the Senate Council member(s) can often undertake when working in partnership with others is to challenge conclusions that do not appear to be evidenced appropriately or where adequate evidence and documentary trails to support the work being done do not exist.

Organisational or sponsor feedback is always useful for all assignments. It can be particularly useful for improvement advice work as it is important to evaluate the
extent to which organisations needs are being met. Mechanisms to gain direct feedback from organisations or sponsors on Senate Council improvement advice work should be put in place.

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If you require this information in another language, format or have general enquiries about Wessex Clinical Senate and its work, contact: england.wessexscn@nhs.net