East Midlands Clinical Senate

North Derbyshire Transformation Programme
Report of the Independent Clinical Senate Review Panel
June 2015

Final Report

england.eastmidlandsclinicalsenate@nhs.net

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East Midlands Clinical Senate

Response to Request for Advice on North Derbyshire Transformation Programme – Bedded Community Care

Prepared for: North Derbyshire Transformation Programme

Approved by: East Midlands Clinical Senate Council

Date: June 2015

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1. FOREWORD BY CLINICAL SENATE CHAIR

Local health and care economies are each facing challenges in making sure that they can respond to the changes in demographics and needs of patients whilst making sure services are sustainable for now and future generations. We need to ensure that the correct balance is achieved between providing accessible services for patients and making sure they are provided with high quality care by well trained and experienced staff.

Clinical Senates have a unique role to play in supporting the NHS in enhancing quality and delivering sustainability by providing independent clinical leadership and advice. We hope that, by bringing an expert clinical voice, we can contribute in a positive way to the future development of bedded community care in North Derbyshire.

I would like to express my thanks to the members of the panel for giving up their time to contribute to this important piece of work, to the North Derbyshire Transformation Programme Team for preparing the detailed, yet accessible, review documentation, and to the East Midlands Clinical Senate support team for coordinating the review and this report.

Our report is purely advisory; however, we hope our advice will support the future development of services for the residents of North Derbyshire.

Professor Dave Rowbotham
Co-Chair East Midlands Clinical Senate

2. ADVICE REQUEST

2.1 The East Midlands Clinical Senate was approached by North Derbyshire CCG and Hardwick CCG to provide independent clinical advice on the North Derbyshire Transformation Programme as part of the NHS England assurance process prior to public consultation.

2.2 The initial contact was made by commissioners in December 2014 with the request to pencil in a review for spring time. Discussions took place in March and April with final clarification of the scope of the request confirmed in May 2015.

2.3 The East Midlands Clinical Senate was asked to review the case for change and planned approach to the development of 'Community Hubs' and answer the following questions:

a. Is the vision in North Derbyshire for developing the options for integrated out of hospital based care, based on sound evidence and best practice?

b. Does the local evidence base and modelling assumptions support the proposed scale of change in relation to community based bedded care?

2.4 The scope of the advice requested did not include reviewing the detailed options for bedded community care as these are still to be developed.

2.5 The information for the panel was prepared by the North Derbyshire Transformation Programme team. A list of the documentation received and reviewed is provided in References (section 7).

2.6 In addition to the review documents, the panel were provided with further supplementary evidence following the review. This is listed in References (section 7).

3. SUMMARY OF KEY RECOMMENDATIONS

Recommendation One:

The panel **supports** the view that the vision in North Derbyshire for developing the options for integrated out of hospital based care is based on sound evidence and best practice, where available. The panel did note that nationally evidence in this area is limited, and there is no national service specification or standards to be complied with. However, the proposals do align with national strategic direction as detailed in the Five Year Forward View, delivering as much as possible in people's homes, local surgeries and communities.

Recommendation Two:

The panel **also supported the view** that, based on the information presented to the panel, the local evidence base and modelling assumptions support the proposed scale of change in relation to community bedded care.

Recommendation Three:

Whilst supporting the two recommendations above, the panel did raise a number of issues that the North Derbyshire transformation team would need to further consider and continue to review as the programme develops:

- Caution was recommended in respect of the evidence available about the impact that community based interventions have on reducing the levels of emergency admissions to hospital, particularly for frail older people (D'Souza S & Guptha S 2013). However, this does appear to be counteracted by local evidence.

- Substantial workforce change is required on a number of levels to realise the proposed model. Significant amounts of care and its associated workforce will need to move from hospital into the community. Alongside this there will need to be a significant change in capability and competencies. A cultural shift may also be required and the panel felt that more detailed work needs to be done to ensure that the workforce, across the board, including GPs, is able and willing to deliver the proposed model.

4. BACKGROUND

4.1 Context

4.1.1 The North Derbyshire Unit of Planning comprises of 2 CCGs, Hardwick CCG and North Derbyshire CCG with a combined total population of 390,000 (Hardwick 102,000, North Derbyshire 288,000). The area has diverse localities ranging from very rural to urban centres. There is variance in the needs of the population e.g. former mining communities have a higher rate of respiratory disorders. The prevalence of long term conditions across the North Derbyshire Unit of Planning is comparatively higher than national and regional averages, and the population is comparatively older. There is significant variation in life expectancy and negative variations in some of the determinants of health. The average life expectancy is slightly lower than the England average (0.4 years) but there is variation of up to 9 years depending on locality.

4.1.2 Local health and care services are provided by one acute trust, two community and/or mental health trusts, 54 GP practices and one local authority. The area is landlocked and therefore borders multiple CCGs and local authorities. Their population also access acute services in Sheffield, Mansfield, Stockport, Macclesfield and Derby City.

4.2 The case for change

4.2.1 The North Derbyshire Team have identified that services are struggling to meet the changing nature of demand where increasingly the ageing population have ongoing complex care needs. Some of the existing services are not resilient due to skills shortages and configuration. If services are not changed, it has been estimated that the system will have a £150m funding gap in 5 years' time.

4.2.2 In addition, a number of reasons have been put forward as to why the services in North Derbyshire need to change:

- Changing needs of the population: the NHS was set up to help sick people get well, often in hospital (episodic care). It is now struggling to meet the changing nature of demand for ongoing complex care.
- Increasing elderly population with the current proportion aged over 75 is 9%; this is higher than national and regional averages with the North Derbyshire Unit of Planning showing a higher prevalence of long term conditions, in particular coronary heart disease, diabetes, and hypertension.
- System capabilities: there are key skills shortages, fragmented services focused on facilities and small isolated wards in the community, and some poor quality estate.
- Financial pressures: NHS funding is flat but demand is growing at 5% per year. Local authorities are facing 28% budget reductions with this adding to the healthcare challenge of £150 million.

4.2.3 Health and Care commissioners and providers in North Derbyshire have worked together to develop a 5 Year Plan for the future of care. The system plan outlines the ambition indicators and targets over the next 5 years, including reducing the amount of time that people spend avoidably in hospital and reducing the number of admissions to residential and nursing home care, through improving the quality of primary and community care and people's ability to self-care. It is also acknowledged that the current approach does not always deliver the best outcomes for individuals and it also sometimes represents poor consumption of the public funding.

4.2.4 As a general rule, approximately 5% of the population will consume 45% of the health resource; however, these patients often do not receive the optimum care for their needs. The overarching recommendation of the plan is to ensure the availability of pro-active, ongoing and interactive care.

4.2.5 All of the commissioners and providers have agreed in principle the direction that the system plan provides and are committed to continuing to work together to develop the plan and deliver the changes where possible.

4.3 National Guidance

4.3.1 The Five Year Forward View (2014), and subsequent planning guidance, highlights the need for the NHS to take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, and health and social care. Primary and community services are the bedrock of people's daily experience of health care. Services should be delivered locally as much as possible in peoples own homes, local services and communities. Some services will need to be provided in specialist centres, organised to support people with multiple health conditions, not just single diseases.

4.3.2 England is too diverse for a 'one size fits all' care model to apply everywhere; nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by NHS national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them appropriately. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care i.e. Multispecialty Community Provider (MCP).

4.3.3 The HSJ/Serco Commission on Hospital Care for Frail Older People (2014) identified that it can be safer and more person-centred to provide care, assessment and support in the homes of older people. Being in hospital can entail repeated ward moves, a rapid loss of mobility and confidence, institutionalisation and risks of harm such as delirium (acute confusion), avoidable bed rest, falls, poor nutrition or infection, poorly coordinated care and delayed discharge from hospital. It is well recognised that patients should be in hospital for the shortest time needed for their acute condition.

4.3.4 Limited evidence is available about the impact that community based interventions have on reducing the levels of emergency admissions to hospital, particularly for frail older people. D'Souza and Guptha (2013) warn that although there are clear benefits of community care such as reduced long term institutional care, there is (as of 2013) scant evidence that the enhancement of community care for frail older people will reduce hospital admissions. They recommended that the effects of enhancing community services should be evaluated before reducing acute care beds. Models of inreach or discharge to assess are still in their infancy and further work nationally is needed to contribute to an evidence base.

5. REVIEW AND RECOMMENDATIONS

5.1 Summary of the proposal

5.1.1 The North Derbyshire Programme team have place integrated care at the heart of their plans. The aim is to be person centred with the need to move from provision that is reactive, specialist, fragmented, organisation centred and dependent "doctor knows best", to proactive, whole person, connected, people and community centred and service user/patient enabled.

5.1.2 The proposal is to create community hubs in North Derbyshire and, in recognition that one size will not fit all, there will be community hubs for 8 geographical communities (the number of community hubs will not necessarily equal the number of service provision centres). Community hubs will, '*provide and support joined up community based care services; developed with local people to meet their needs'*.

5.1.3 The proposal for community bedded care is to move from the current baseline position of 125 to 76 beds by 2019. This will be achieved by balancing an anticipated 4% growth per annum with the system plan to provide right care in the right setting and avoiding growth in demand.

5.1.4 For older people with mental health conditions, predominantly patients with dementia, the proposal is to move from the current baseline position of 50 to 30 beds by 2019. Again, the proposal is that the anticipated growth will be mitigated by the right care in the right setting and also the services provided by the dementia rapid response team.

5.2 Proposal for community bedded services in North Derbyshire

5.2.1 The North Derbyshire Transformation Team gave an overview of the programme in a presentation supported by pre-circulated documentation. The three strategic aims are to keep people:

- safe & healthy – free from crisis and exacerbation;
- at home – out of social and healthcare beds;
- independent – managing with minimum support.

5.2.2 Integrated care is at the heart of the plans. The proposal is to deliver these aims by responding to the changing needs of the population by shifting the focus of care to person centred and coordinated care, rather than organisation focused and fragmented. The case for change was outlined and this was summarised under the headings of the changing needs of the population, system capabilities, financial pressures and local care needs.

5.2.3 Eight geographical communities have been defined with the proposal that these will be served by 'community hubs' that can respond and adapt to local needs, '*Community hubs will provide and support joined up community based care services; developed with local people to meet their needs.'* The community hubs were broadly described in that they will offer urgent, planned and bedded care to complement services provided at home and in hospitals – delivering right care, in the right setting, by the right people.

5.2.4 The overarching aim is to provide integrated care closer to home for the patients, and to keep patients healthier for longer helping them stay out of hospitals, by creating community hubs where multidisciplinary teams work in partnership with other healthcare sectors including social services to provide joined up care to patients within their community.

5.2.5 The proposal for community bedded care is to move from the current baseline position of 125 to 76 beds by 2019. This will be achieved by balancing an anticipated 4% growth per annum with the system plan to provide right care in the right setting and avoiding growth in demand.

5.2.6 For older people with mental health conditions, predominantly patients with dementia, the proposal is to move from the current baseline position of 50 to 30 beds by 2019. Again, the proposal is that the anticipated growth will be mitigated by the right care in the right setting and also the services provided by the proposed Dementia Rapid Response Team; which will be developed in stages utilising resources freed up by the stepwise release of beds.

5.3 Panel Review

5.3.1 The review panel asked the team to provide more information around the evidence being used to support the proposals. In respect of bed numbers, the Emergency Care Intensive Support Team (ECIST) (now known as NHS Interim Management and Support) undertook a review in 2013 and recommended that discharge planning and proactive identification of patients be improved in order to inform the longer term community bed requirements.

5.3.2 Subsequently, Finnamores were appointed to undertake bed modelling work and this was used to inform the proposals detailed. Local Public Health at Derbyshire County Council has also undertaken an assessment of acute beds. The assessment was undertaken in 2014 and a summary document was written for the Derbyshire wide Chief Executive group of health and social care commissioners and providers in May 2014. The focus for this was acute hospital beds and the modelling suggested that there may be an excess of beds for an optimally resourced and functioning health and social care system.

5.3.3 A number of services have already been put in place that have had a positive impact on avoiding admissions for people who do not need to access hospital care. One such example is the Falls Partnership Service (FPS). Historically, patients who have had a fall call an ambulance, get taken to A&E and are often admitted unnecessarily. The Falls Partnership Service is an alternative to an ambulance crew attending. A response from the Falls Partnership Service can result in patients being able to remain in their own home, where appropriate, to receive care. An evaluation of the service shows that out of 255 patients seen, only 6% (n=15) were admitted to hospital. This service has been supported by advanced nurse practitioners employed in the acute frailty unit who are able to assess whether admission is required.

5.3.4 Other cited examples included: (i) Implementation of 'JONAH' software that assists the management of patient care pathways and targets where discharges may be delayed. This has resulted in a reduction of length of stay (LOS) from 65 to 21 days on average; (ii) increased access to community based Pulmonary rehabilitation for patients with chronic respiratory conditions; (iii)The voluntary single point of access (VSPA) service is to provide one referral route into health and social care voluntary services to support people to receive services at home or as close to home as is possible; (iv) quantitative and qualitative evaluation of pilot GP practice based virtual wards across North Derbyshire.

5.3.5 The review panel raised concern about the potential impact of a reduction in acute beds in parallel with changes to community provision. Although the scope of the proposals presented does not include secondary care service provision, Chesterfield Royal NHS Foundation Trust has been integral to the programme. The review panel were assured by the acute trust representative that they were supportive of the developments being proposed. It was highlighted that beds have already been reduced by 80 across the acute trust provision and this has not resulted in increased pressure on the acute trust or in a rise in readmissions because of new service developments put into place. Three whole system 'perfect weeks' had been held resulting in 90 beds being empty at the end of the week, demonstrating that when services are running efficiently there is still capacity in the system. Rotational working is also being introduced to enable staff from the acute trust to understand the whole patient journey.

5.3.6 The number of geographical communities and community hubs being proposed was discussed and whether they would be able to effectively serve their population, in particular the High Peak locality. It is a geographically large area but has a similar population number compared with the other hubs. Similar work in Lincolnshire around 'neighbourhood teams' is based on a population of approximately 50,000 per team. The number of geographical communities does not necessarily equate to a physical hub and innovations, such as virtual hubs, may need to be utilised. There could be multiple places from which services are delivered within a community or places may be shared across more than one community. This will be determined through the process by consideration of options for how best to meet the needs**.**

5.3.7 Issues around workforce were discussed both in absolute numbers of staff to deliver the model being proposed and also in skills required in respect of staff potentially moving from acute trusts to community based services and any new roles being developed. Care for patients accessing community based services is likely to be multidisciplinary in nature with a wide range of professions requiring the competencies and skills to support patients accessing services outside of hospital. Health Education East Midlands (HEEM) have been commissioned to undertake a baseline assessment of services and to model the future requirements along with a skills analysis. As well as looking at workforce numbers and skills required, HEEM is also reviewing education programmes for the workforce. A detailed report was produced in April 2015, workforce mapping had been undertaken and modelling work that identified that the key focus needs to be on ensuring staff transfers from inpatient settings and the upskilling of the existing community workforce. The report did not detail how this is going to be achieved.

5.3.8 A question was raised about the practicalities of joint funding and affordability. Whilst the review of finances sits outside of the remit of the Clinical Senate, it was noted that the aspiration was for each community to have a pooled budget to enable locally developed approaches to delivering healthcare with the same outcomes.

5.3.9 A query was raised as to how patients would be empowered. Examples of proven interventions where patients were given the opportunity to learn more about their conditions and to seek help from those with similar conditions were described by the team such as that of the Pulmonary rehabilitation programme, as a result of which patients are better placed to self-manage their condition and have the opportunity to join Breathe Easy support groups. The establishment of the 'Breathe Easy' support groups was patient led and are patient run. Similar services are already in existence for other types of diseases including diabetes where education for newly diagnosed patients is commissioned, and frailty where healthcare well-being plans are used to enable patients have full control of their care plans.

5.3.10 There was also a question around IT systems and information governance as joined up care will inevitably lead to patient information being shared across different sectors of healthcare. North Derbyshire has been using Rightcare© plans for the past 10 years; many patients are on this patient record system already and have given informed consent about relevant information being shared. This, however, does not offer a perfect solution around information sharing and governance and so the team are continuing to look into possible solutions. It was noted that this is a universal problem faced by similar organisations across the country.

5.4 Recommendations

5.4.1 It was very clear from the information provided, presentations and discussions held at the review panel that there are strong working relationships across all health partners and adult social care with a unified view of the direction of travel and how to get there driven by doing the right thing for patients.

5.4.2 The proposals put forward were supported by evidence in respect of modelling work, service reviews and evaluation and measurement of the impacts of new service provision. A comprehensive information pack was supplied to the review panel prior to the panel meeting. During the review additional verbal evidence was given and this was supported by documentation provided by the North Derbyshire team post panel meeting.

5.4.3 Based on the information presented and the supplementary evidence provided the panel made the following recommendations:

Recommendation One:

The panel **supports** the view that the vision in North Derbyshire for developing the options for integrated out of hospital based care is based on sound evidence and best practice, where available. The panel did note that nationally evidence in this area is limited, and there is no national service specification or standards to be complied with. However, the proposals do align with national strategic direction as detailed in the Five Year Forward View, delivering as much as possible in people's homes, local surgeries and communities.

Recommendation Two:

The panel **also supported the view** that, based on the information presented to the panel, the local evidence base and modelling assumptions support the proposed scale of change in relation to community bedded care.

Recommendation Three:

Whilst supporting the two recommendations above, the panel did raise a number of issues that the North Derbyshire transformation team would need to further consider and continue to review as the programme develops:

- Caution was recommended in respect of the evidence available about the impact that community based interventions have on reducing the levels of emergency admissions to hospital, particularly for frail older people (D'Souza S & Guptha S 2013). However, this does appear to be counteracted by local evidence.

- Substantial workforce change is required on a number of levels to realise the proposed model. Significant amounts of care and its associated workforce will need to move from hospital into the community. Alongside this there will need to be a significant change in capability and competencies. A cultural shift may also be required and the panel felt that more detailed work needs to be done to ensure that the workforce, across the board, including GPs, is able and willing to deliver the proposed model.

7. REFERENCES

1. NHS ENGLAND. (2014) *Five Year Forward View.* http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
2. NORTH DERBYSHIRE JOINED UP CARE. (2014) *Community Hubs Strategic Outline Case*.
3. D'Souza S & Guptha S (2013). *Preventing Admission of Older People to Hospital* BMJ 2013:346
4. North Derbyshire Unit of Planning (June 2014) *System Plan*
5. North Derbyshire JoinedUpCare (November 2014) *Community Hubs Strategic Outline Case*
6. North Derbyshire 21C #JoinedUpCare *Community Hubs Timeline*
7. North Derbyshire 21C #JoinedUpCare (February 2015) *Feedback Summary*
8. North Derbyshire 21C #JoinedUpCare *Understanding the work to date: Baseline*
9. North Derbyshire 21C #JoinedUpCare (April 2015) *Community Hubs – Planning assumptions*
10. North Derbyshire 21C #JoinedUpCare *Refining the options and developing the shortlists*
11. North Derbyshire Transformation Programme (June 2015) *Presentation*
12. *North Derbyshire Unit of Planning – Community Hubs (Bedded Care) (June 2015) Clinical Senate Review Follow Up Information*
13. *Outputs from the population need for emergency hospital beds in Derbyshire modelling 2014*
14. *Reshaping Community Workforce: Project report summary April 2015*
15. *Derbyshire Community Health Services JONAH Business Case May 2014*
16. *Hardwick CCG Falls Partnership Service (FPS) Project Second Evaluation Report June 2014*
17. *Breathe Easy Hardwick South Carer's Impact Survey Results*
18. *Breathe Easy Hardwick South Patient Impact Survey Results*
19. *Breathe Easy Hardwick North Carer's Impact Survey Results*
20. *Breathe Easy Hardwick North Patient Impact Survey Results*

8. GLOSSARY OF TERMS

BLF	British Lung Foundation
COPD	Chronic Obstructive Pulmonary Disease
CRH	Chesterfield Royal Hospital
DRH	Derby Royal Hospital
ECIST	Emergency Care Intensive Support Team
FPS	Falls Partnership Service
GC	Geographical Community
HEEM	Health Education East Midlands
IC	Integrated care
LOS	Length of stay
LTC	Long term condition
MCP	Multispecialty Community Provider
MH	Mental health
ND UoP	North Derbyshire Unit of Planning
OPMH	Older people's mental health
PRISM	Profiling Risk, Integrated Care and Self Management
SOC	Strategic outline case
VSPA	Voluntary Single Point of Access

9. APPENDICES

Appendix 1 – Membership of the review panel

Name	Title	Organisation
Professor Dave Rowbotham	East Midlands Clinical Senate Co-chair	East Midlands Strategic Clinical Networks & Clinical Senate
Ali Aamer	Community/hospital based geriatrician	Nottingham University Hospitals NHS Trust
Keith Spurr	East Midlands Clinical Senate Patient Representative	East Midlands Strategic Clinical Networks & Clinical Senate
Mangesh Marudkar	Consultant Psychiatrist for Older Adults	University Hospitals of Leicester NHS Trust
Tracy Means	Clinical Team Leader/ Complex Case Manager/ Queen's Nurse	Lincolnshire Community Health Services NHS Trust

Professor David J Rowbotham MB ChB, MD, MRCP, FRCA, FFPMRCA – Panel Chair
Clinical Director, NIHR Clinical Research Network
Co-chair, East Midlands Clinical Senate
David Rowbotham is Clinical Director of the NIHR Clinical Research Network: East Midlands and Emeritus Professor of Anaesthesia and Pain Management, University of Leicester. Other current roles include: advisory board member, East Midlands Academic Health Science Network; council member and treasurer, Royal College of Anaesthetists; advisor to the British National Formulary; Civilian Advisor in Anaesthesia, Royal Navy; and Director and board member, British Journal of Anaesthesia. Past responsibilities include: Consultant in Anaesthesia and Pain Management, University Hospitals of Leicester; Clinical Director, Leicestershire, Northamptonshire and Rutland Local Comprehensive Research Network; Director of Research and Development, University Hospitals of Leicester; Dean, Faculty of Pain Medicine, Royal College of Anaesthetists; Chair, National Institute for Academic Anaesthesia; and Vice President, Association of Anaesthetists of Great Britain and Ireland.

Dr Mangesh Marudkar MBBS, MD, DNBE MRCPsych, PhD – Panel Member
Consultant Psychiatrist for Older Adults, Leicestershire Partnership NHS Trust
Mangesh Marudkar is a Consultant Psychiatrist for Older Adults in Leicestershire since 2001.
He is also an Executive Committee member of the Faculty of Old Age Psychiatry (Yorral College of Psychiatrist) since June 2014. He was formerly the Associate Medical Director (Medical Education) at the Leicestershire Partnership NHS Trust (2009 - 2013) and the Postgraduate Course Organise (2002-2009).

Ali Aamer – Panel Member
Community / Hospital Based Geriatrician
Nottingham University Hospital NHS Trust
Ali Aamer has worked in general medicine and geriatric medicine for over fifteen years in both teaching and district general hospitals in the UK. As a consultant, he has experience of working as a clinical lead for fall and osteoporosis, audit and clinical governance. For the last 2 years, he has been the head of department for geriatric medicine. It is his desire to help to develop a team of professionals providing a complete hospital admission service.

Tracy Means – Panel Member
Clinical Team Leader / Complex Case Manager / Queen's Nurse
Lincolnshire Community Health Services NHS Trust
Tracy Means has worked in the NHS for almost thirty years in a variety of nursing roles. In the last 16 years she has focused her career on the primary care sector, and has been a qualified District Nurse for twelve years.
Currently she leads a large community nursing team on the East Coast of Lincolnshire, as well as leading on the development and implementation of the Care Home Support Team. This is a new service aimed at providing education and ward rounds within the care home environment to help reduce unnecessary hospital admissions.
As a Queens Nurse she is actively involved in promoting and developing primary care services both locally and nationally.

Keith Spurr – Panel Member
Patient Representative
East Midlands Clinical Senate
Keith Spurr is a retired experienced HR Advisor/Business Partner providing generalist HR support to organisations of varying sizes, within all types of industry for 40 years. He was an accredited Trade Union Representative when he represented ex-employees at Tribunals liaising with solicitors, courts, CMDs, PHRs and Full Hearings. Therefore, he has experience as both a manager and as a Trade Union representative and can appreciate both sides of the "table" whilst at the same time represent individuals and groups as required. He has worked with organisations as part of their change programme. He is diabetic Type 1 and had a TIA 25 years ago. He is the Diabetes UK Champion for the South Lincolnshire Area and a diabetic "voice".

Appendix 2 – Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Dave Rowbotham (Chair)	None	None	None	None
Ali Aamer	None	None	None	None
Keith Spurr	None	None	None	None
Mangesh Marudkar	None	None	None	None
Tracy Means	None	None	None	None

Appendix 3 – Notes of panel meeting

MINUTES OF NORTH DERBYSHIRE TRANSFORMATION PROGRAMME [21C]
EAST MIDLANDS CLINICAL SENATE REVIEW PANEL
WEDNESDAY 3 JUNE 2015 12.30PM – 4PM
DUNSTON INNOVATION CENTRE, DUNSTON ROAD, CHESTERFIELD, S41 8NG

East Midlands Clinical Senate:

David Rowbotham (**DR**)	East Midlands Clinical Senate Co-chair, Chair
Sarah Hughes (**SH**)	East Midlands Clinical Senate Manager
Ali Aamer (**AA**)	Community/Hospital Based Geriatrician
Keith Spurr (**KS**)	East Midlands Clinical Senate Patient Representative
Mangesh Marudkar (**MM**)	Consultant Psychiatrist for Older Adults
Tracy Means (**TM**)	Clinical Team Leader/Complex Case Manager/Queen's Nurse

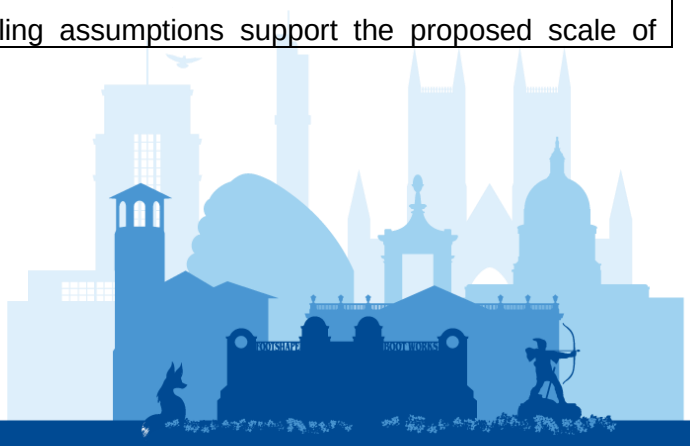
North Derbyshire Transformation Programme Team:

Andrew Milroy (**AM**)	Assistant Director Adult Care
Andy Gregory (**AG**)	NHS Hardwick CCG Chief Operating Officer
Jackie Pendleton (**JP**)	NHS North Derbyshire CCG Chief Operating Officer
Justin Walker (**JW**)	GP
Kathleen Shakespeare (**KSh**)	Consultant Geriatrician
Mark Whittingham (**MW**)	Consultant Psychiatrist
Rick Meredith (**RM**)	Medical Director
Ruth Cooper (**RC**)	GP
Sukhi Mahil (**SM**)	Community Hubs Programme Manager
William Jones (**WJ**)	Director of Operations

Present:

Sheila Darji (**SD**)	EM Clinical Senate PA & minute taker
Hye-Jung Chi (**HC**)	EM Clinical Senate Assistant & minute taker

1.	**Panel Pre-meeting –** DR opened the pre meeting with a welcome and brief introductions were made around the table. Panel members were asked to declare if they had a conflict of interest – none were declared. DR and SH provided a brief overview of the review with reference to the Terms of Reference, and clarified the role of the Clinical Senate independent review panel. DR reminded the panel of the two questions in the terms of reference: 1. Is the vision in north Derbyshire for developing the options for integrated hospital based care, based on sound evidence and best practice? 2. Does the local evidence base and modelling assumptions support the proposed scale of



	change in relation to community based bedded care? Some questions were raised during this process and DR summarised them to be asked as points of clarification to the North Derbyshire Transformation Programme Team. These questions were: a) What models or evidence were the facts and figures based on? Explanations around these may be needed. b) Older People's Mental Health services provision will need to be clarified – what does this include? What does 'acute' mean in this setting? c) Will need robust plan around information governance in the new joined up models. d) Some information may need to be provided by the team. The process of the review and administrative tasks post-review were explained. It was noted that, as the programme is yet to go out to public consultation, all discussions and information around this programme was to be kept confidential until further notice.
2.	**North Derbyshire Transformation Programme Presentation** The programme team joined the table and a round of introductions were made. **The presentation** Rick Meredith gave a brief presentation outlining: The case for change, three strategic aims, how North Derbyshire aims to deliver them, and their visions. The North Derbyshire Transformation Programme is based on strong, quality working relationship across the sectors in health and social care, and the drive for this programme is to do the right thing for patients. <u>Why change?</u> The current service provision model is not sustainable in the face of changing needs of the population. Integrated care will provide solution to this and ensure safe and good quality care to patients in a sustainable way. <u>What is integrated care?</u> It is person centred as opposed to organisation centred and the care pathway is joined up and coordinated in a seamless way. <u>Not 'one size fits all'</u> Eight geographic communities (GCs) have been identified in North Derbyshire that will serve the 390,000 population of the area, which all have different population needs. Each GC will be able to provide local solutions that best suit the population they serve by creating community hubs. <u>What are community hubs?</u> Community hubs will provide and support joined up community based care services;

developed with local people to meet their needs.
The number of hubs will not equal that of the GCs, and the GC's will provide as many community hubs as necessary to meet the demands of the population.
The proposed bedded care model
This model focuses on moving more towards care being provided at home and relying less on bedded care as this is best for patients.
Community bedded care
Future demand was estimated by the team with aspirations of what sustainable looks like. The figures presented do not include beds in private sector.
Where are we now and what next?
The team have so far carried out 4 workshops, and are in the second phase of their fifth workshop. The outcome of this workshop will determine what services are needed in each of the community hubs. Such process will be repeated on a learning by experience basis in order to adapt to local needs.

Questions and discussion
DR opened the question time by requesting clarification around the local evidence that the panel is asked to consider in question 2. The question was met with enthusiastic responses around proven interventions and/or models that were successful in North Derbyshire.
RM commented that North Derbyshire has a great number of community beds, and by referencing Richard Asher's 1942 literature 'staircase to dependence' in which he advocates for restoring independence to patients as soon as possible, made a case for reducing the length of stay.
North Derbyshire has successfully implemented 'JONAH' software package to reduce length of stay and in the best practice case, it has gone down from 60 days to 17 days (average 20 days). Emergency Care Intensive Support Team (ECIST) had undertaken a review of bed numbers a few years ago.

The North Derbyshire Transformation Programme is gaining increasing support from academics and clinical colleagues due to local evidence.
Another successful intervention in reducing admission to hospital and length of stay was seen in falls. The majority of falls patients will call an ambulance, transported to an A&E and admitted into hospital for lengthy and, often, unnecessary tests. A process is now in place in North Derbyshire where if a patient calls 999 with a fall and if bone fracture is not suspected, a *falls recovery team* is sent out instead of an ambulance, thereby ensuring the patient stays home while care is given. When this project was first initiated the team were given 2 years for cost recovery which was achieved in less than a year.

Acute Frailty Units (AFUs) in North Derbyshire are staffed by advanced nurse practitioners who are able to assess patients on whether they need to be admitted to hospital.

There was some disparity about implementation of bed reductions as ideally beds will be

	reduced on evidence that such action leads to improvement in service, however it appears that some changes will need to be made at pace to enable overall implementation of the programme. North Derbyshire are looking at 7 day services, and some services including the falls service are commissioned 6 days already. Question 2: Another question was posed around empowering patients; how do the team propose to do this? Once again examples of successful intervention were given such as that of Chronic Obstructive Pulmonary Disease (COPD) where they invested in pulmonary rehabilitations and a support group 'Breathe Easy' facilitated by British Lung Foundation (BLF) in communities. The two were commissioned concurrently which enabled joined up transition of patients out of hospitals into communities, and saved hospital admissions (quantified as £410,000). Similar examples of education and enablement programmes exist for diabetes (commissioning of education for newly diagnosed diabetic patients) and frailty (healthcare well-being plans which patients fill out themselves). Question 3: During the presentation it was mentioned that specialist care was not considered in the proposed bedded care model. A question was raised against this as the programme needs to be a collaboration of all sectors. This led into workforce issues and North Derbyshire's approach to them. Health Education East Midlands (HEEM) is commissioned to propose a model to solve workforce issues in North Derbyshire where a baseline exercise is undertaken and future needs (5 years) are projected. This still leaves the question of whether the required workforce will be filled, however, as the service provision model shifts in the future, so will the workforce. As well as looking at the workforce and numbers and skills required HEEM is also reviewing education programmes for the workforce is also being discussed with HEEM. An issue was raised around funding integration, i.e. will the funds be pooled. Under the Better Care programme social care and CCGs will come together and the aspiration is that each community will have one pooled budget to enable variable approaches to delivering healthcare with the same outcomes. However, this issue is outside the remit of the Clinical Senate. Question 4: The fact that secondary care was not mentioned in the presentation was brought up. As the programme is on community services, secondary care is not included in the scopes however, it is still an integral part of the process. Alignment with care homes was also raised as an issue; each practice has a social worker to support this alignment. North Derbyshire have piloted virtual wards in practices across North Derbyshire with core groups consisting of General Practitioner, matron, district nurse, care co-ordinator and physiotherapist to deliver better service. Quantitative and qualitative evaluations are carried

	out frequently with such pilots and so far the results have been consistent. North Derbyshire have a well-established Voluntary Single Point of Access (V-SPA) where voluntary care coordinators liaise with carers. It has proven to be a good tool for identifying gaps where investments can be made by the commissioners. The V-SPA provides a single phone number for all communities and has access to clinical information on the systems. It enables anticipatory care plans of patients for out of hours services. Question 5: A questions around IT systems and access was raised, as well as issues around information governance when patient information is shared across different sectors of healthcare. North Derbyshire has been using Rightcare© for the past 10 years and all patients on MRC have given informed consent about relevant information being shared. However, this still does not provide a solution to issues around information governance and the team are looking into this. Question 6: The last question before the panel convened for a discussion was to whether there were any organisations/partners who are not signed up to this programme, and the level of engagement with stakeholders. All partners and organisations are signed up and there have been several meetings with around 6,000 staff members across organisations for extensive, cross-organisational engagements. The North Derbyshire team left the room to enable a further panel discussion.
3.	**Panel discussion** Concerns were raised around some of the background information. The local evidence provided at the review was verbal and the panel would like to see the source documentation. Discussion took place around what further documents/evidence the panel may want from the team. Documents around workforce (current pictures and projections) were among those identified as well as a number of key evaluation reports. The number of GCs (8) was also questioned as there were doubts whether the 8 GCs would be able to effectively serve the seemingly large proportions of population [refer to Item 2 'Community hubs strategic outline case' page 5]. GC number 8 (High Peak) in particular raised concerns as this seems much more isolated. It was noted however, that High Peak was an area with lower population density so would be serving a similar size of population as all the other GCs. Lincolnshire community hubs serve around 50,000 population per hub and it appears that the proposed 8 GCs in North Derbyshire will serve similar sized populations. There used to be national guidelines around the minimum number of beds provided per certain number of population but the data are outdated and so are not valid anymore.

	It was recommended that the team should capture meaningful data from the programme as they move forward to inform subsequent years. A question was raised around whether the community hubs are focused primarily on the top 5-10% of the population with complex needs or on the whole population. Concern over the figures was raised once more and further documented evidence would help the panel understand the rationale behind the reduction in beds needed to support the population.
4.	**North Derbyshire Transformation Programme Question Session** A question around acute beds was asked to the team. In Chesterfield Royal Hospital (CRH) 80 beds are already closed and the trajectory is going down. Furthermore, North Derbyshire is the only place in the country to have carried out a whole system "Perfect Week" in Autumn 2014 and Spring 2015, and by the end of the week around 90 beds were empty. [Refer to Item 6 'Community hubs – planning assumptions' page 9]. A discussion then took place around Older People's Mental Health Services. Work that is already being carried out have been highlighted such as Airedale CCG's tele-health implementation being carried out where secure skype line is used to carry out consultations at home. Southern Derbyshire, North Derbyshire and Yorkshire have collectively put forward an application as a vanguard site of networked working called Profiling Risk, Integrated Care and Self Management (PRISM). An acute trust's perspective was brought into the discussion by a representative from CRH who testified that the acute trusts in North Derbyshire are very committed and engaged with the programme and a number of schemes are already developing including discharge assessment schemes which are intrinsically linked with the community hubs to support patients. Acute trusts are also trying to develop rotational working to enable following patients through the entire care pathways. When a concern was raised around reducing the number of beds in both acute trusts and in the community, it was highlighted that it is already happening and that it is proven to work as CRH has not felt any increase in readmissions nor any increase in the pressure as a trust. The key is in work on improving the flow of patients. The concern should not be on the number of beds but on the location of beds, i.e. the team needs to understand where the needs are. The discharge assessment is just for the AFUs currently but North Derbyshire are looking to

	roll this out to other wards in the acute trusts. The concern over the number of hubs and their spread across North Derbyshire was raised again but the panel was assured that the number of GCs does not equal the number of community hubs. Local solutions to the configuration of hubs will also ensure that the larger GCs are not disadvantaged (for example the use of virtual hubs, spokes etc to cover wider areas). There was worry over the quality of care provided by 'federation doctors' but the panel were once again assured that the issues to deal with are only around workforce and not skills or quality.
5.	**Panel discussion II** All panel members felt that the questions raised were answered satisfactorily and are happy to answer the two questions posed to them. There is still a note of caution around the modelling assumptions and may need to ask for further documents and evidence to view for the report writing. The panel agreed unanimously that the models as presented are workable.
6.	**Feedback to North Derbyshire Transformation Team** DR thanked the team for the summary provided with relevant documents and pages sign-posted which the panel found to be useful. He also congratulated them on their extensive work done already and the cohesiveness of their responses which impressed the panel members. He informed the team that the East Midlands Clinical Senate panel were supportive of the proposed models but wished to see more documents in support of this.
7.	**Close** DR thanked the team and the panel and concluded by reminding colleagues of the timescale for reporting. A first draft of the report to be sent to panel members within 10 days of the meeting, comments from the panel to be returned within a week, report sent to the north Derbyshire team for matters of factual accuracy with the final report issued by 30 June. The report will be published following public consultation.

Appendix 4 – Full terms of reference of the panel

EAST MIDLANDS CLINICAL SENATE INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

Title: North Derbyshire Transformation Programme
Sponsoring Organisation: North Derbyshire & Hardwick CCG
Clinical Senate: East Midlands Clinical Senate
NHS England regional or area team: Midlands & East, Central Midlands
Terms of reference agreed by:
Name: Professor Dave Rowbotham **on behalf Clinical Senate and**
Name: Sukhi Mahil on **behalf of** North Derbyshire & Hardwick CCGs
Date: 26.05.2015

Clinical review team members

Chair or lead member: Professor Dave Rowbotham, Chair East Midlands Clinical Senate
Members –

Professor Dave Rowbotham	EM Clinical Senate Co-chair
Sarah Hughes	EM Clinical Senate Manager
Dr Mangesh Marudkar	Consultant Psychiatrist for Older Adults Leicestershire Partnership NHS Trust
Ali Aamer	Community/hospital based geriatrician Nottingham University Hospital NHS Trust
Tracy Means	Clinical Team Leader/ Complex Case Manager/ Queen's Nurse Lincolnshire Community Health Services NHS Trust
Keith Spurr	Patient Representative EM Clinical Senate

Aims and objectives of the clinical review

The review requested by North Derbyshire Transformation Programme is a Clinical Senate review as an input to NHS England assurance prior to public consultation on proposals around services for bedded care in North Derbyshire, with a particular focus on services for older people.

Scope of the review

The main focus of the review is to consider the case for change and planned approach to the development of the 'Community hubs' to answer the following questions:

1. Is the vision in North Derbyshire for developing the options for integrated out of hospital based care, based on sound evidence and best practice?

2. Does the local evidence base and modelling assumptions support the proposed scale of change in relation to community based bedded care?

Further detail is provided in supporting papers.
When reviewing the case for change the Clinical Review Panel may want to consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care?
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Do the proposals reflect the goals of the NHS Outcomes Framework
- Do the proposals reflect the rights and pledges in the NHS Constitution
- Do the proposals meet the current and future healthcare needs of their patients

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement.

Timeline

There has been on-going informal engagement between the Senate and Sukhi Mahil (North Derbyshire Community Hubs Project).
Background information, modelling assumptions and other supporting information will be shared with the Senate prior to a Clinical Review Panel scheduled for 3 June 2015.
North Derbyshire Transformation Programme planning assumes a three week turnaround of the Senate report back to North Derbyshire Transformation Programme for input to the NHS England check point.

Reporting arrangements

The clinical review team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.
Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The Senate review will consist of a face to face review panel with presentations from the North Derbyshire Transformation team.

Report
A draft clinical senate assurance report will be circulated within10 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking. Comments/ correction must be received within 5 working days.
The final report will be submitted to the sponsoring organisation by 30 June.

Communication and media handling
Dates and arrangements for publication and dissemination of report and associated information. To include identified lead person, where report will be published, press releases/conferences, meetings with patent groups, public, staff and boards, health and wellbeing boards and Health overview and scrutiny committees

Resources
The East Midlands Clinical Senate will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.
The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance
The clinical review team is part of the East Midlands Clinical Senate accountability and governance structure.
The East Midlands Clinical Senate is a non statutory advisory body and will submit the report to the sponsoring organisation.
The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles
The **sponsoring organisation** will

- provide for the clinical review panel all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions).
- respond within the agreed timescale to the draft report on matter of factual inaccuracy.
- undertake not to attempt to unduly influence any members of the clinical review team during the review.
- submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisation will

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

Clinical Senate council will

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

Clinical review team will

- undertake its review in line the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
- keep accurate notes of meetings.

Clinical review team members will undertake to

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

END

Appendix 5 – Contact Details

For information relating to this report please contact:

England.eastmidlandsclinicalsenate@nhs.net