Principles for Developing Community Reconfiguration Proposals

10th November 2016

1. Background

As Sustainability and Transformation Plans (STPs) are being developed across the 6 STP footprints in the South West, the Clinical Senate is increasingly being asked to provide independent clinical review of plans for community transformation.

The Senate can give clinical advice to the 11 CCGs in the South West both as an early advice giver and more formally 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.

There have been some key themes running through Senate advice on the topic of community transformation and reconfiguration to date, both in the South West and elsewhere across England. The South West Clinical Senate along with other Senates has commonly noted concerns around workforce as a key example. Many Senates have also found that the documentation submitted to describe the clinical model can be extremely lengthy, yet at the same time not highlighting sufficiently some of the key facts and detail around development.

It was therefore considered that it would be beneficial to develop some general principles for community reconfiguration that CCGs and STPs could refer to when developing models of care. It is intended that the Senate could then review community reconfiguration proposals by exception where the following principles are not met, making the test 3 review process less onerous whilst also sharing key learning and research from around the country.

The following principles have been developed based on previous Senate advice, clinical reviews already undertaken in the South West, reviews undertaken by other Clinical Senates, the findings of a literature review considering the evidence for community reconfiguration and the findings from the Clinical Senate session on 10th November.

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2. Overview

Whilst decisions around a particular model of care must not be pre-determined prior to public consultation, there needs to be assurance that different options pertaining to a given model of care have been sufficiently explored to understand which are viable, what is required to deliver them and the impact different configurations might have.

Overall a clinical senate review panel would expect a clinical model to demonstrate how it supports integration across all sectors of health care with quality assurance and sustainability built into it, linking between health & social care, describing the leadership of 'the system' itself and the metrics

that will be used to track and demonstrate success. Consideration of innovative contracting models, sustainability and timescales beyond 2020 would ideally be evident.

When developing a model of care for community transformation and the options for implementation the Senate recommends that the following is taken into account in order to ensure any large scale service change is well planned and that there is a good fit between the evidence base, case for change and detail of the clinical model including changes in activity and workforce. The model needs robust clinical engagement and should demonstrate that it will improve the quality of care for patients and that the system is made simpler and easier for patients to navigate as a consequence.

The information recommended below supports the Senate Checklist (appendix 1) for all stage 2 reviews. Everything below does not necessarily need to be covered off prior to consultation but it is required prior to implementation. Feedback from our South West Citizen's Assembly has also confirmed that clear information is also useful in supporting consultation processes (appendix 2).

3. Evidence for Community Reconfigurations

I. Movement towards primary care consolidation is supported by the Senate and fits with the concept of the multispecialty community provider. This 'primary and community care at scale', where clinical hubs serve a minimum registered population of 30,000 patients acts as a natural home for a selection of staff (E.g. DSNs, CPNs, counsellors, physio & OTs, health educators, care coordinators, pharmacists, links with specialists, 7/7 OOH provision). The size has sufficient critical mass to function efficiently but is not so large as to weaken relationships on which good coordination and teamwork depends.

II. There is broad support for well thought through models of community reconfiguration moving towards an increase in place based care. This is in line with the policy direction set out by Five Year Forward View. The Senate's literature search and ongoing review in this area suggests that this is an emergent area for research and evaluation.

    a. However, it is recommended that existing services are not withdrawn until other community services and associated workforce are ready to go live unless it is clear that the service under consideration is no longer needed.

    b. Furthermore, given the limited evidence available that community based interventions reduce levels of admissions to acute hospitals, caution is recommended in respect of the impact upon activity that changes to services may have.

III. There is some clear evidence where acute provider models can support community services;

    a. There is evidence of the benefits of acute provider same day discharge to assess models. The Sheffield 'discharge to assess' model and its benefits is described at: http://www.health.org.uk/media_manager/public/75/publications_pdfs/Improving%20the%20flow%20of%20older%20people.pdf

b. Comprehensive Geriatric Assessments are evidenced as having very positive effects and should be performed on admission to hospital on all patients with moderate or severe frailty to help determine (or modify existing) treatment plans, including plans for discharge and long term care.

c. The availability of a 'Care Navigator' for all patients being discharged from acute trusts was identified by the Senate in May 2014 as being a top priority to enable patients with additional needs following discharge to access intended services. Care Navigators could be non-clinical or clinical as appropriate and would support individual episodes of care. They would act in an advocacy role and as a single point of contact for patients requiring complex care packages.

4. Detail around Models of Care

I. It is important to be able to clearly articulate the programme of work, the current status and overall timeline via one or two succinct documents that go beyond communications designed for public consultation. This is also recommended to support internal NHS communications, CCG planning and reporting on this model of care going forwards.

II. Articulation of the clinical model should include the interdependencies with other services and how the model will be flexed to meet the needs of different groups;

a. Mental health provision must be described as part of any place based care model.
b. Clear illustration of the relationship with urgent care including urgent care networks is required.
c. Clear illustration of the relationship with primary care is key. How GPs realistically link into placed based care and any impact upon them or unintended consequences need to be considered.
d. The links with and provision of social care need to be accurately described and an understanding of residential and nursing home bed capacity and utilisation demonstrated.

III. Evidence shows that there can be significant variation in what a community hospital, virtual ward or clinical hub for example can mean in different parts of the country. Similarly, interpretation of integration in Healthcare Services varies considerably.

a. Information therefore needs to be provided regarding the clinical model for different services and sites, including radiology and pathology / near-patient testing.

b. A clear description of what services and staff a clinical 'hub' or 'single point of access' entails should be included.

c. Where community hospital beds may close, clarification regarding how remaining community beds will be used more effectively and how "active rehabilitation" will be delivered should be provided.

5. Workforce

I. Substantial workforce change is likely to be required on a number of levels to realise many of the proposed models for community transformation. Significant amounts of care and its associated workforce will need to move from hospitals 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 detailed work must be demonstrated to ensure that the workforce, across the board, including GPs, is able and willing to deliver the proposed model.

II. Health Education England no longer commissions non-medical education and STPs and CCGs need to develop relationships with education providers and build local capacity to provide trainee placements in the future to ensure workforce sustainability.

Workforce planning should ask;

a. Is the clinical model sufficiently developed to enable review of workforce requirements and interventions, with evidence of clinical engagement?

b. What are the workforce implications of the proposed new models of care?

1. What is the vision for an integrated health and social care workforce?
2. Is the workforce affordable?
3. Is that workforce available and have recruitment timelines been considered?
4. What will the workforce look like in terms of skills, diversity and behaviours?
5. What development of upskilling, new roles and new ways of working is needed?
6. Have you considered the policies and implications for mobile staff and lone working?
7. What are the implications for those providing self-care, unpaid carers and volunteers?
8. What is the implementation plan and timeline for workforce development?

III. Detail outlining the workforce that will deliver the new clinical model must be provided. This should include a breakdown of current staff, their skills and details of the proposed training strategy and breakdown of proposed new roles prior to implementation. A future recruitment and retention risk assessment should be provided.

IV. Detail of how the Local Workforce Action Board (LWAB) (or equivalent) is engaged with and supporting the workforce element of the service change proposals should be provided.

a. The LWAB should be using one of the 3 key framework tools to initiate the workforce planning process for service change. These include the Calderdale framework (links to population epidemiology), the Population Centric framework (uses pen portraits of service users) and The 6 Steps framework. More detailed modelling will be supported by other tools such as the WRaPT (Workforce Repository and Planning Tool). Each STP has resource from Health Education England to support implementation of this tool.

6. Information Management and Technology

I. Shared access to information systems is vital to support effective, accurate communication and to avoid duplication. Consideration of this must be evidenced within the proposals, particularly with a view to supporting a more mobile workforce.

a. It is recommended that commissioners and providers (health and local authority) across South West STPs should set the same standards for their clinical IM&T systems to encourage interoperability and compatibility across the system.

b. Evidence reviews have found that there is very little to no evidence that tele-medicine reduces activity and caution over the reliance of tele-medicine to support models of care is advised.

7. Clinical Engagement

I. Widespread clinical engagement and leadership in the service change needs to be described beyond CCG clinical leadership eg to include other community providers, voluntary and 3rd sector and providers of GP groupings such as federations.

II. The clinical leadership model to support staff delivering place based and intermediate care across the community needs to be provided to demonstrate that the model does not rely on *ad hoc* relationships for quality and safety.

III. A social partnership forum with trade unions should be in place to support staff engagement in the change process.

IV. Staff in the acute sector should be engaged in supporting changes to community services by talking to them about the plans.

8. Appendices
Available on request in a zip file from sarah.redka@nhs.net

9. Pre-Reading
1. Senate Checklist
2. Evaluation of Integration and Community Based Care – Nuffield Trust, June 2013
3. The Torbay Journey to Integration – LGA Case Study, 2016
4. Moving Healthcare Closer to Home – Monitor, 2015

5. East Midlands Clinical Senate – Clinical Review Report on North Derbyshire Community Transformation Programme
6. Place Based Systems of Care – Hugh Alderwick, King's Fund, Nov 2015
7. South Devon and Torbay – Community Services Transformation Clinical Review Report
8. NEW Devon CCG – Community Services Transformation Clinical Review Report
9. South West Clinical Senate – June 2014 Advice on Discharges to Community Settings
10. Summary of the outcomes of the two literature reviews commissioned by the Senate.
11. Reducing Avoidable Hospital Admissions – SEC Clinical Senate

10. Presentations to the Senate Council

12. Population Healthcare - Sir Muir Gray
13. Primary Care Setting – Dr Phil Yates
14. Workforce Strategy and Planning – Dr Claire Hines
15. The evidence, or lack of, for community transformation -Professor Sarah Purdy
16. Integration case study – Karen Frankland, Nottingham City Care
17. South West Citizens' Assembly response

These principles and the background material will be shared with the South West CCGs and STPs as well as the other 11 Clinical Senates across England.