South West Clinical Senate

Principles for Reconfiguration: Advice for STPs

South West Clinical Senate 2017

As Sustainability and Transformation Partnerships (STPs) continue to develop across the South West, the Clinical Senate is increasingly being asked to provide both early independent clinical advice and formal independent clinical review of plans for large scale change and service transformation to inform the NHS England assurance process.

Evidence shows that true change can take up to 30 years to be fully delivered. The current pace of change, pressure on the healthcare system and reduced funds available mean that any transformation proposals need to be more robust than ever to identify the best clinical models and plan for effective implementation.

The Clinical Senate strongly recommends that a whole systems approach to transformation is essential. The interface between community and acute hospital services need to be clear; one part of the system cannot be properly considered in isolation without being mindful of unintended consequences.
There have been some key themes and concerns emerging through Clinical Senate reviews of service change both in the South West and elsewhere across England and as a result these overarching principles for reconfiguration have been developed. The intention is that they can be used as an early guide for STPs to refer to when developing models of care and to illustrate the key issues a clinical review might consider in order that they can be addressed early on to strengthen overall models of care.

They incorporate and build on the outputs of council sessions held to review learning and evidence on reconfiguration for community proposals (10th November 2016), wider clinical review (30th March 2017), the patient voice (28th June 2017) and acute proposals (13th July 2017). These final principles have also taken into consideration the content of STPs nationally, evidence for transformation and case studies of proposals and clinical reviews recently undertaken. Notably the Citizens' Assembly principles that were developed to consider purely the public and patient perspective on large scale service change and experience of consultation concurred largely with the key themes emerging from clinical discussion. Furthermore of note is that following a prioritisation exercise, workforce was singled out as the topic of greatest concern for all. Council session outputs are available at www.swsenate.nhs.uk

Transformation plans can commonly lack articulation of detail pre-consultation, despite the development of an overwhelming amount of background documentation and information. This is in part because the consultation process itself has a crucial role in identifying preferred models. However not all proposals are as fully and clearly explained as they could be within the documentation provided for review. There is some concern that the public often do not understand the issues behind and implications of proposals. 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.

The only options to be presented should be those that have a real possibility of implementation. Part of the Clinical Senate's role in reviewing the clinical model and evidence base for change is to seek assurance that described pathways can be delivered, and understand what the anticipated outcomes will be. The pace of change leading up to consultation needs to be realistic from the outset and allow for proper development of robust options with consideration to what implementation plans might look like.

There is a Senate challenge to STPs in the South West to robustly work up more radical proposals in order to be able to more effectively tackle the challenges our health system is facing. There is broad support for well thought through models of community reconfiguration moving towards an increase in place based care and primary and community care at scale while the concentration of expertise on acute sites is often clinically sound. Whilst the Senate's ongoing evidence review of reconfiguration suggests that these are emergent areas for research and evaluation, they are in line with the policy direction set out by Five Year Forward View.

Principles:

When developing emergent options for large scale service change the Senate recommends that the following are taken into account in order to ensure there is a good fit between the evidence base, case for change and detail of the clinical model particularly including changes in activity and workforce:

1. **Workforce**
   Substantial workforce change is likely to be required on a number of levels to realise any proposed models for transformation, with the argument that the development of models should begin with workforce. Along-side 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 is available, able and willing to deliver the emergent model.

   a. A sense check of workforce models must be included at stage one and two as a stand-alone assurance item. Assurance of large scale service change should give consideration to the development of a 'staffing/person test', similarly to the 'bed test' concept. Detail outlining the workforce that will deliver the new clinical models 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.

   b. Workforce resource must be properly thought through in options development including; type of staff, level of staff, availability of staff and timescales for recruitment, rotas, training for clinical and non-clinical staff, the impact on junior doctor training and numbers, accreditation, support for and roles of out of hospital staff, integration of non-NHS staff and the impact on GPs and ancillary staff, the implications for research and the implications for those providing self-care, unpaid carers and volunteers.

   c. 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.

      Each Local Workforce Action Board (LWAB) should be using one of the 3 key framework tools to initiate the workforce planning process for service change. Each STP has resource from Health Education England to support implementation of this tool to help understand;

   - Is the workforce affordable?

- Is that workforce available and have recruitment timelines been considered?
- What will the workforce look like in terms of skills and what training is required?

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.

(As a result of this work highlighting workforce as the number one concern for transformation proposals, the Clinical Senate Council and HEE are running a Senate Council on 1st February 2018 to review the workforce in the South West against proposed future transformation. Outputs will be available on the Senate website.)

2. Whole Systems Approach

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 whilst also adding to the body of evidence required to support transformation. Consideration of innovative contracting models, sustainability and timescales beyond 2020 would ideally be evident.

a. Whole system models may focus on one key area such as acute or community services but they must show clearly how the clinical model takes into account interdependencies with other services and how the model will be flexed to meet the needs of different groups, with unintended consequences considered;

I. Impact on and interface with 111, front door, diagnostics, pharmacy, private care, ambulance services, mental health provision, learning disability provision, diagnostics, pharmacy , specialised commissioning pathways and home and ancillary care provision etc.
II. Consideration of care pathways across artificial geographical boundaries.
III. Clear illustration of acute care or other networks and links to other providers is required.
IV. Referral patterns and access particularly for patients with chronic illnesses needs to be factored in.
V. Transport practicalities can impact the safety of a clinical model if poorly planned.
VI. Robust models will demonstrate realistic and comparable patient walk-through outcomes and experiences to test models.
VII. 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 where relevant demonstrated.
VIII. Clear illustration of the capacity available and relationship between primary/GP/community and urgent care is required.
IX. There should be clarity around SOPs and governance for trans-local services to include any formal networking arrangements and what they will mean in practice.
X. Consider how non NHS providers will be integrated and held equally to account for quality of service provision.

3. Clinical Engagement

Early and meaningful involvement of clinicians and staff in addition to the public is essential and must be clearly demonstrated;

a. Shared decision making can change patient pathways and impact demand management. Widespread clinical engagement and leadership in any proposed service change needs to be described beyond CCG clinical leadership.

b. The acceptability of a proposed workforce model must be tested out with the workforce it affects.

c. There should be clear clinical governance agreed around who has patient responsibility.

d. The clinical leadership model to support staff delivering place based and out of hospital care needs to be provided to demonstrate that the model does not rely on ad hoc relationships for quality and safety.

4. Describing the Model of Care

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.

a. Proposed models should be clear about which options are genuinely viable and which are not and why.
b. Realistic timescales for implementation should also be outlined.
c. Provide clear detail of the impact the service change will have on the level and quality of a service including waiting times and continuity of care.
d. Provide clear definitions for service descriptors (eg. place based care/clinical hub/ambulatory care/virtual wards/UCC) as evidence shows that they do not necessarily have the same meanings across the NHS.
e. Where beds may close, provide clarification regarding how remaining beds will be used.
f. It must be possible to link data at a population level; how can improved outcomes and finances be ensured in the model.
g. Where services are changing, demonstrate how equity of access has been taken into account.
h. What are the implications for travel times and cost for all types of transport and for ambulance services?
i. Equality and Quality Impact Assessments should be completed and made available to the Senate.

5. **Information Management**

a. Shared access to information systems is vital to support effective, accurate communication and to avoid duplication across all providers of care.
b. Provide clear detail around what technology will support home and self-care and how.
c. Education around new pathways is fundamental to their success and ensuring different services don't open up demand. Consideration of this must be evidenced within the proposals.
d. 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.

6. **Implementation Plans**
    a. Where services are changing significantly or ceasing to run, the new model must be fully functional with staggered introduction as appropriate before original services cease.
    b. Be clear about how the impact of service change will be measured to gather evidence for the future.

7. **Evidence**

    a. Be clear as to the available evidence base and whether there is any evidence of best practice and this model working elsewhere.
    b. Given the limited evidence available that community based interventions reduce levels of admissions to acute hospitals other than that for discharge to assess models, caution is recommended in respect of the impact upon activity that changes to services may have.
    c. 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.
    d. The availability of a 'Care Navigator' for all patients being discharged from acute trusts has been identified as a key enabler for 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.
    e. 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.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
    f. When considering a whole systems approach there is clear evidence as to the overall benefits a local healthcare system of implementing stopping smoking interventions described by the Senate (www.swsenate.nhs.uk)
    g. When considering transformation that includes acute emergency services the South West Clinical Senate undertook a review of emergency general surgery (EGS) services and identified 6 key recommendations to improve EGS services.(www.swsenate.nhs.uk)

The NHS England document 'Supporting Service Change' provides a helpful guide to the service change assurance process and is available on the Senate website or from the administrator at sarah.redka@nhs.net