Clinical Senate
Yorkshire and the Humber

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THE MID YORKSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

TRANSFORMATION PROGRAMME OUTLINE BUSINESS CASE

YORKSHIRE AND THE HUMBER SENATE REVIEW

The Mid Yorkshire Meeting the Challenge Programme Executive Group, on behalf of the Mid Yorkshire Health and Social Care Transformation Programme, requested the Yorkshire and the Humber Clinical Senate to review their Outline Business Case (OBC) version 2.6, dated 5th December 2013, and provide advice regarding the case for change, the assumptions regarding changes in services and its impact upon quality of care and clinical practice. The following report contains the Senate panel review.

The OBC seeks to articulate a strategic case for transformational change and the development of a range of health and social care services within the Mid Yorkshire footprint. The OBC is strongly aligned to the delivery of a Full Business Case (FBC) related to the reconfiguration of acute hospital services within the Mid Yorkshire Hospital Trust – the alignment relates specifically to enabling the reduction in approximately 171 hospital beds over the next 3 years. The FBC was not made available to the Senate in its initial review completed 28th January 2014 and therefore the comments related only to the OBC. In line with the Programme Executive Group's request version 1 of the report was compiled by reading of the Outline Business Case without further detailed discussion with authors of the report.

On receipt of the initial report dated 28th January 2014 the Programme Executive Group requested opportunity for further discussion on the content of the report. It was agreed that in order for the Senate to fully understand the proposals for maternity services the relevant documentation from the Mid Yorkshire Hospitals NHS Trust Full Business Case was needed and this was made available to members of the Senate panel in March 2014. Initial comments on the maternity section were revised in the light of this additional information. This version 2 of the Senate report was provided to the programme sponsors in May for final comment.

Version 2 of the report also revises the Senate comments on public engagement as it was agreed that this goes outside of the scope of the requested Senate advice. Version 2 does not amend the comments on the other sections of the report. It is understood however the Senate comments are based on the information contained within version 2.6 of the OBC

which reflect the commissioners thinking at that point in time. Commissioner’s proposals may have developed further since our report on these sections was completed.

It should also be noted that the Senate was still in development in December 2013 when the request for review was received. It was therefore agreed with the programme sponsor that the advice would be developed from a bespoke group of clinical experts from within Yorkshire and the Humber, who are independent to the organisations under discussion, and were already known to the SCN and Senate team. All panel members have areas of expertise particularly related to the issues within the business case.

The final report will be available to the public on the Senate website (yhsenate@wordpress.com)

1. Introduction

1.1 The panel commends North Kirklees and Wakefield CCGs for the content and scope of their business case which is comprehensive and describes several innovative and new ways of working which might improve patient care.

1.2 The documents advance the case for a comprehensive, multi-partner change initiative in Mid Yorkshire, which envisages root and branch organisational, strategic and cultural shifts in the planning, organisation and delivery of health and social care services in the target area. Urgent Care, Care Closer to Home, Maternity, and Mental Health Care are specifically focussed on, with the goal of ensuring that

- "Patients are practically managed at or close to their homes;
- only those patients who need to be in hospital are admitted; and
- once admitted into hospital, patients only stay for as long as is clinically necessary"

1.3 The above aims and goals entail moving towards:

- Full integration of health and social care provision,
- ...in order that hospital care is offered only to those people who really need acute/specialist treatment and care,
- ... thereby maximising admission prevention/avoidance, through delivering high quality, safe experience/outcomes as a result of adoption of new models of integrated community care services for patients, their carers, and the community at large,

1.4 The panel note the commendable consensus approach and close alignment of the high level ambitions to national policies.

1.5 At the outset, however, it is important to note that the services described in this paper are designed to complement a potential major service change in the Mid-Yorkshire Hospitals Trust's described on the 'Clinical Services Strategy' (CSS). The CSS is briefly referred to in the OBC but is not described in any detail. This has made it more difficult for the panel to engage with the OBC and to fully judge the effects on patient care and the likelihood of true transformational change. On the basis of the information provided in the OBC the panel felt it would be difficult for an MP or councillor to explain the proposals to the general public and to easily understand the evidence base

1.6 The panel also made 3 broad observations:

1.6.1 The panel have been assured that commissioners have considered and evaluated the evidence base for their service models and have taken this into account in the development of their proposals. It is recognised, however, that for many of these proposals the evidence base is limited. There is some evidence base that specific interventions can reduce the need for in hospital care but the wider evidence base to support the "system type" of interventions (hospital at home / virtual ward / case

management etc.) is of a poorer quality. The panel felt that the paper would benefit from greater clarity on how the proposed pilot schemes will be evaluated, by whom and using what methodology as careful, thorough and methodical evaluation needs to be central to these developments.

1.6.2 The panel has not considered the finances of these proposals but notes that there is limited detail about whether the economy is considering new commissioning / contracting models and or new forms of payment to facilitate this change. There is a risk that continued use of PBR will only serve to embed current practice and commissioners may wish to explore the viability of alternative contracting models

1.6.3 The level of detail with regard to joint working with the Local Authority could be further developed. It is not clear how the extent of Local Authority budget cuts has been factored into these plans and commissioners need to ensure that the OBC is not too NHS oriented in its presentation. The panel has been advised that the Better Care Fund submission provides more clarity about this and this submission was in development during the time of this review.

1.7 There follows a detailed review of each of the 4 major service areas and additional comments on and the inclusion of children and young people although this was not in the scope of the OBC

2. Urgent Care

2.1 This section brings together a range of proposals to deliver an integrated 24 hour urgent care system across the Mid Yorkshire health and social care economy.

2.2 The panel are agreed that North Kirklees / Wakefield has significant capacity problems both in terms of staffing and inpatient capacity and are agreed that it is unlikely that 3 A&E departments can be sustained in their current form the longer term. The service models described in the paper to give integrated alternatives to A&E are very good and the integration of Primary Care within the hospitals' emergency/urgent care units is excellent.

2.3 The panel felt, however, that more information was needed in Appendix H to understand the analysis of a projected reduction in emergency bed days and the assumptions that underpin this. The panel also felt that they could not gain a clear understanding of the relationship between the proposed development of the different parts of the patient's pathway, particularly the timeline, to ensure that community services are funded and developed before savings from reduction in admissions can be realised.

2.4 There are concerns that apply to any proposals for an integrated model regarding whether the patients will change their patterns of self-referral. Educating patients on how to use urgent and emergency services is key to the success of these proposals and it was felt that the OBC did not provide sufficient detail on how this will be achieved. Making it easier for patients to navigate is essential and this has to be done alongside an ongoing information campaign about how to use their particular GP practice. All practices differ in the way patients access appointments and this has increasingly not helped patients to make the "right" choice.

2.5 The panel made the following observations in their review:

2.5.1 It is important that the Emergency Day Units and Hospital Admission Avoidance Teams have the necessary specialist skills and training to assess vulnerable groups of patients including older people and those with dementia. These patients need to have appropriate tests before being discharged with a good system of handover to community teams on discharge. The panel advises that the care pathways should incorporate appropriate arrangements for review and follow up of these patients as some patients (particularly older people) often present in a non-specific manner and problems can develop which were not immediately obvious on initial presentation. The function of these teams would be optimised if they included senior representatives from the Elderly Care Department.

2.5.2 Seamless systems depend on shared paperwork and computer systems and the community should strive for shared paperwork for DNAR/EOL/Care plans etc. across the community and the acute trust. The operational care pathways also need to be sufficiently robust to ensure patient information flows with the patient through community based care. Robust shared pathways and a shared understanding of what primary care and acute trusts can do is essential – community matrons and

advanced medical practitioners as well as therapists could spend some time in the hospital to help to reduce these barriers.

2.5.3 Communicating with primary care is often very difficult to achieve. Different practices have different attitudes to providing trusts with reliable well manned numbers and this needs to be addressed. Whilst the OBC refers to engaging with primary care it talks of this in terms of engaging with CCGs, but engagement with GPs as the frontline clinicians is key. There needs to be a cultural change from “assess to discharge” to “discharge to re-enable” and this involves supporting the intermediate care teams in the community sufficiently for them to feel empowered to cope with taking on “risk” as appropriate. This may be in the form of easy access to consultant advice

2.5.4 Senior decision makers are crucial and these need to be in A&E and in the community. GP practices need to ensure that all clinical staff are sufficiently supported to look at “alternatives” and not just go for the path of least resistance.

2.5.5 GPs attached to ambulance crews have significantly reduced conveyance rates to hospital in 2 recent large pilots. Using this approach alongside “hear and treat” and the “see and treat” (as proposed in the OBC) has been shown to be successful in other areas. A diversion of “falls calls” to a specific falls team may also prove useful.

2.5.6 The ambulance crews need a reliable and responsive telephone number from all the GP practices so that they can discuss alternatives to conveying patients to hospital easily without delaying their workload.

2.5.7 Sufficient resource is required in the community so that the service does not struggle when there is increased sickness / school holidays / weekends and out of hours.

3. Care Closer to Home

3.1 This programme proposes the development of community-based health and social care integrated initiatives to enable adults (particularly the frail and/or elderly and adults with long-term conditions) to live more independent lives.

3.2 There are three strands to this programme, Proactive care, Crisis intervention and Early supported discharge. These three strands impact on prevention and self-care, admission avoidance and Early Supported Discharge (ESD):

- Admission avoidance (for unnecessary admissions) and admission prevention (by earlier intervention to prevent admission becoming necessary), thereby reducing the number of hospital admissions

- Early Supported Discharge (ESD) to provide timely and effective discharge arrangements that help people leave hospital once they no longer require acute care, and ensure that their on-going care needs are met.

3.3 The panel felt that the current layout and content of the proposed Outline Business Case does not allow clear conclusions to be drawn in relation to these areas. Whilst the overall direction of travel is well described – "care closer to home" – there is little detail presented. Unnecessary admission is obviously a core theme throughout these proposals. The definition of the term is rather sparse however and the panel felt that some further explanation of the % of bed days (or admissions) that are considered "unnecessary" would be helpful.

3.4 The panel noted that:

3.4.1 Current service configuration, as a baseline to interpret the proposed changes, is not provided.

3.4.2 Current service quality and efficiency information data are not presented e.g. benchmarking the existing services against national data would allow some inferences about potential for improvements.

3.4.3 No demand estimates are presented for the proposed new community services and no capacity estimates for the new services – will they be big enough to make a difference? The proposals need to ensure equality across practices in terms of access to community nursing, community matrons, rapid response teams, IV antibiotics, OOH GP access etc.

3.4.4 What mechanisms for integration are being proposed? – E.g. shared records; between service access; involvement of third sector; involvement of mental health services.

3.4.5 What service response times are being proposed for performance monitoring?

3.5 The main emphasis was on home-based care. But most health and social care communities have a mixed community-based bed and home team approach. It is not clear what the provision of community bed based care is going to be (it is not in the

overall diagram on page 24). The emphasis seems to be on getting people out of hospital to home with support which is not always appropriate and which does not fit with the aims of correct care in the correct place at the correct time. Home may be desirable but it is not always the most appropriate. The panel referenced the case study of Ivy on page 48. There were concerns whether twice daily visits from carers would prove sufficient or if the model of a convalescent/intermediate setting would be more appropriate. The panel did accept that there are often problems in the process of ensuring that the intermediate places are available when required (and do not cause delays to discharge) but returning to an empty home when you are frail and have broken your hip does not seem an ideal model of care.

3.6 The panel felt that there needs to be further clarity regarding which patients need more specialist care. There are many occasions in which there could be an extra bullet point/paragraph explaining that the process of early evaluation of patients nearer home should allow for early identification of patients who need more urgent/more specialist care, and therefore earlier referral. This is very much the idea of an integrated service that is central to the network approach to care and could be emphasised further within this document. A clear process to identify and triage more complex patients or pathology will allow the community service to focus on the more straightforward problems which do not need referral, therefore saving resource.

Admissions Avoidance

3.7 As a general point the panel emphasised that it is crucial to provide any patient whose admission is avoided or prevented with appropriate assessment and to have appropriate plans in place to support them at home. There also needs to be clear and robust mechanisms to review the patients and to modify plans should problems occur. The arrangements for 'out of hours' advice and support need to be clear.

3.8 Commissioners are advised to consider the following specific points:

3.8.1 The Hospital Admission Avoidance Teams (HAAT) and pathways require the expertise (from both Medicine for the Elderly and Mental Health) to ensure that 'admission avoidance' and management in the community is appropriate for the patient.

3.8.2 Has consideration been given to the arrangements which will be put in place to ensure these patients (whose admission is avoided) are *routinely reviewed* to ensure they are progressing satisfactorily?

3.8.3 Further information would be helpful to consider the out of hours medical cover and support arrangements should problems occur. It is not clear who the patient or carer can call at night for help should help/advice be needed e.g. should the patient become confused.

3.8.4 It would be helpful to understand what existing experience there is for the proposal of locally based community teams. What will the composition of the teams look like and their training and leadership? Community nursing teams need to be staffed

sufficiently to respond quickly to patients who suddenly deteriorate and require more intensive input. It is also not clear what plans are in place for the ‘medical’ assessment for patients being cared for by these teams (GP, ANP, CM, or Geriatrician). The community teams would be strengthened if there is ready access to specialist advice in the community. It is recommended that some of the consultant geriatricians have a community focus to support the development of these programmes.

3.8.5 Practice teams are advised to use data to identify their most vulnerable patients and ensure prophylactic steps are taken to prevent crises. When admissions occur they need to “pull” patients out of hospital as quickly as possible.

3.8.6 Access to social care needs to be integrated into the “single point of access” and the provision of community beds need to be considered when short term intensive input is required but acute admission offers no benefit. Hardwick CCG in N Derbyshire has successfully used practice attached social workers in their virtual ward model.

3.8.7 “Day unit” capacity in any proposed frail elderly unit at the trust may offer good alternatives to admissions ensuring elderly patients have only one trip to hospital for investigations/consultant opinion without the need for multiple visits to the hospital and /or admission.

Early Supported Discharge (ESD)

3.9 Within the information provided the plans described for ESD seem likely to improve both bed utilisation and patient care. The panel advises that the commissioners should give particular consideration to patients with dementia within this scheme to ensure that they are not denied access to ESD schemes because of their confusion. This has been the experience with some ESD schemes elsewhere in the UK.

4. Maternity, Children and Young People (Safe and Healthy Pregnancy)

4.1 This section proposes a model of care that supports the CSS proposal to centralise consultant obstetric maternity beds onto one site and to provide two 'stand-alone' and one 'alongside' midwifery led units/ birth centres across North Kirklees and Wakefield. This model promotes the need for fewer obstetric led interventions in pregnancy and more normalised births in birth centres and homes.

4.2 The panel assessed that the main benefit to this proposal is in the staffing of the units. The proposals will allow for an increased number of staff for a single unit rather than stretching staff across 2 units. The plan is for 24 hour resident senior obstetric staff for the consultant unit at Pinderfields which fits with the RCOG recommendations. The panel welcomed the proposal for there to be a separate on call rota for gynaecology.

4.3 The panel welcomed the investment into Pinderfields to facilitate the development of this new model. This investment will increase the size of the consultant unit and develop a new midwifery led birthing unit.

4.4 The panel noted that the increase in elective throughput is to be planned separately from the acute work and there will be a separate theatre so the acute work will not affect the running of the elective list. In total there will be 3 obstetric theatres, one for the elective work and 2 for the acute work. The panel supports these planning proposals.

4.5 The panel welcomed the work undertaken with the Yorkshire Ambulance Service to undertake a feasibility exercise to assess the transfer times between Dewsbury and Pinderfields which the panel felt to be an important part of the considerations for this model.

4.6 The panel noted that the assessment process for booking women as low risk will be the same for the midwifery led birthing units at all 3 sites. There are 500 proposed births at the Dewsbury site which does make the postnatal transfer of babies less of a concern as this number of low risk deliveries will only generate a relatively small number of babies needing acute transfer. It is noted that paediatric staff will be on site 12 hours a day and overnight acute support will be provided by anaesthetic staff. The panel emphasised the importance of ensuring that these anaesthetists are NLS trained. The panel also emphasised the need to ensure close monitoring of all infants overnight. With there being no paediatric staff on site out of hours it is important to ensure the midwives can identify unwell infants overnight, discuss this with colleagues at Pinderfields and transfer them for further care.

4.7 The panel are supportive of the proposals to change the current 27 neonatal cots (12 at Dewsbury and 15 at Pinderfields) to 23 cots at Pinderfields with a 4 – 6 cot transitional care bay based on the postnatal ward. The panel advised that the proposed CRG calculator for neonatal capacity suggests that the Trust's activity last year would require 2 IC, 3 HD and 20 SC cots. This can easily be accommodated within the cot model proposed. The panel also welcomed the preparation undertaken

by the Trust, running a 4 bed transitional care unit at Dewsbury since March, which has worked well.

4.8 The paper is based on this proposal being financially cost-neutral but there is a risk of loss of income based on those women who currently deliver at the in-patient unit in Dewsbury deciding not to deliver at Wakefield but in a neighbouring unit that is geographically nearer such as Calderdale or Bradford. The panel noted that the maternity pathway payments have been mapped and it is not anticipated there will be a significant loss of revenue.

5. Mental Health (Liaison Psychiatry)

5.1 The main thrust of this programme is the provision of a hospital based psychiatric liaison service for people aged over 18 years. This recommendation stemmed from an independent review by Dr Sean Cross, Consultant Liaison Psychiatrist at South London and Maudsley NHS Foundation Trust, in response to a rule 43 letter issued by the Coroner

5.2 The objectives of the proposed service are to ensure that adults with mental health problems who attend the acute hospitals are sign-posted to the most appropriate care, receive parity of care for physical and mental health needs, are not admitted merely to avoid breaching the emergency care target and receive ongoing psychiatric assessment so that they can be discharged once medically fit.

5.3 There is evidence that Hospital Liaison Teams provide better quality care and also can reduce patient stays. Leeds has had Mental Health Liaison Teams for several years which work well. However the LSE evaluation of the Birmingham RAID model contained many optimistic assumptions which have yet to be proven.

5.4 The panel supports this proposal as described but makes the following comments:

5.4.1 There is a need to ensure this team liaises in turn with the community integrated health and social care teams to ensure patients get appropriate care and support after discharge. There is also a need to ensure parity of esteem for dementia patients.

5.4.2 The OBC makes little mention of co morbid physical / mental health from the perspective of primary care. There is also little referral to the broader impact of austerity on mental wellbeing – a good proportion of which will track through to peoples use of mental health care and exacerbating physical illness. The panel acknowledges that both of the above examples are difficult to quantify, but both may have a significant impact on the development of the plans

5.4.3 The panel were also aware of examples from Derby City and Chesterfield Royal Hospital who have put, or have plans to put, acute psychiatry into the Emergency Department. In Derby City this has reduced the time spent in ED and bed days for patients with mental health problems, with significant improvement in the quality and onward management of their care.

6. Young people

6.1 The panel felt that there is little mention of children or young people in the OBC. Whilst the panel acknowledges that this patient group are not the focus of the community plans they will be affected by some of the same issues, particularly around delayed discharge from hospital due to social/medical problems which could be managed in the community. Similarly there are issues with increasing (often unnecessary) children's attendances to A&E as other out of hours services are not adequate (also bearing in mind that many GP's are unhappy/untrained in paediatrics.)

6.2 The following specific points are noted:

6.2.1 Young people are mentioned in the title for maternity care where the purpose is clearly pre-and post-natal care. It is not clear why young people are mentioned in the title

6.2.2 Public concerns about children's services are noted on page 41 but these are not addressed within the document proposals

6.2.3 On page 107 children get mentioned as key feature of new ED depts. There is however no detail provided on the resources required for them, no mention of triaging children versus adults or provision of separate services/areas for children or indeed need for safeguarding provisions.

6.2.4 Page 168 refers to safeguarding children within the title but the text within this section refers purely to adults.

7. Next Steps

7.1 The Senate thanks the Mid Yorkshire Meeting the Challenge Programme Executive for the opportunity to comment on these proposals and we hope that the review has highlighted some potential areas for further development.

7.2 We are keen for the programme sponsor to have opportunity to questions any points of accuracy within the report and also for the Senate to understand whether this report has met your brief in terms of providing advice regarding the case for change, the assumptions regarding changes in services and its impact upon quality of care and clinical practice.

7.3 Please contact Joanne Poole, the Senate Manager, to raise any queries with the accuracy of this report by 14th May. Once finalised, the report will be placed on the Senate website

7.4 It would be very helpful for the Senate to determine the impact of the Senate advice and the Senate Manager will therefore contact you 3 months following the publication of the report to discuss this with you.

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