The Future of Local Health Services in Northern Staffordshire

Information Briefing
Reference Group
2nd May 2018

Agenda

- 2pm Where we have got to since we last met: Dr Lorna Clarson
- 2.15 The Options Development Process: Anna Collins
- 2.30 Principles of future services and proposals for delivery: Dr Lorna Clarson
- 2.45 Understanding the information: Matt Oakes
- 2.50 Feedback & Questions
- 3.00 Next Steps & Close

Why We are Here

Dr Lorna Clarson: Clinical Director for Partnership & Engagement

- To recap on where we have got to
- To share some terminology
- To help you to understand the data and information and modelling that has been done
- To prepare you for our next workshop on 10th May

To Co-Produce the options on which we will consult

Pre-Consultation Engagement and the Modelling

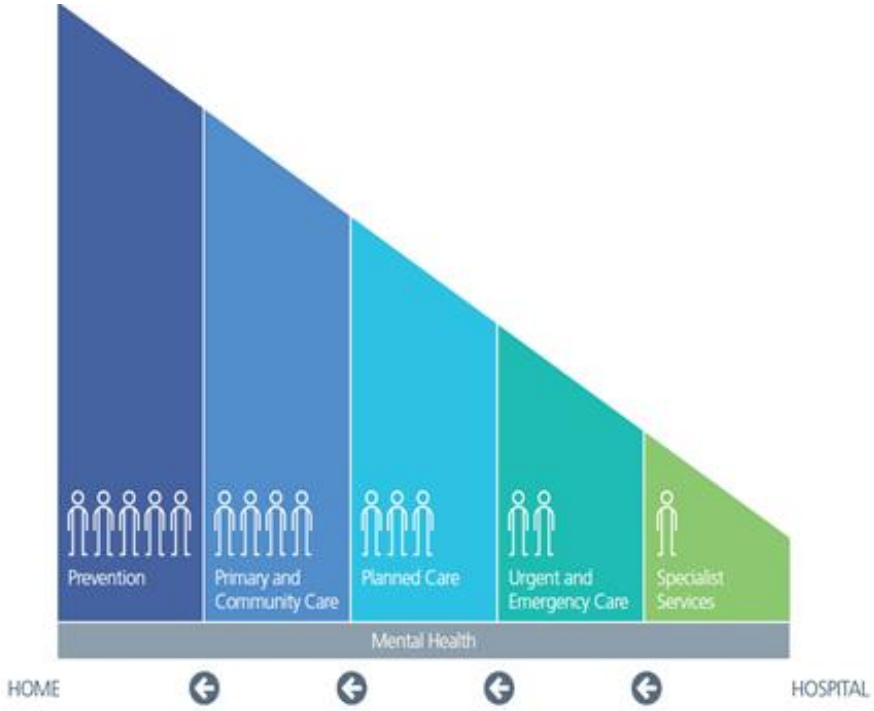
The purpose of the pre-consultation was to:-

- provide meaningful information upon which stakeholders had sufficient understanding to get involved;
- gather information and listen to ideas
- use the information provided to consider the opinions expressed to develop our proposals for formal consultation.

The options developed for the future provision of health services will be co-produced with members of the public and stakeholders.

Areas of Focus

- We are re-designing services which to date have been/are being provided within or around the five Community Hospital sites (Bradwell, Cheadle, Longton, Leek and Haywood).
- We are developing new ways of working as outlined in a range of national strategies.
- Our aim is to keep as many people as possible towards the left of the diagram with health and care professionals working in co-located multi-disciplinary teams.
- 5 broad areas (below) have been identified through the pre-consultation events which are underpinned by a menu of services.
    - Urgent care and diagnostics
    - Integrated Community Teams incorporating long term conditions management and frailty
    - Dementia and Mental Health
    - Planned Care
    - Beds



The CCG Vision

Our Mission (why we are here)

We commission safe, accessible, high quality services to improve the health outcomes and meet the clinical needs of the people of Stoke-on-Trent and North Staffordshire.

Our Vision (where we are going)

We will be more effective and innovative commissioners of better health outcomes by delivering the principle of 'Home First' through care at home and community based services.

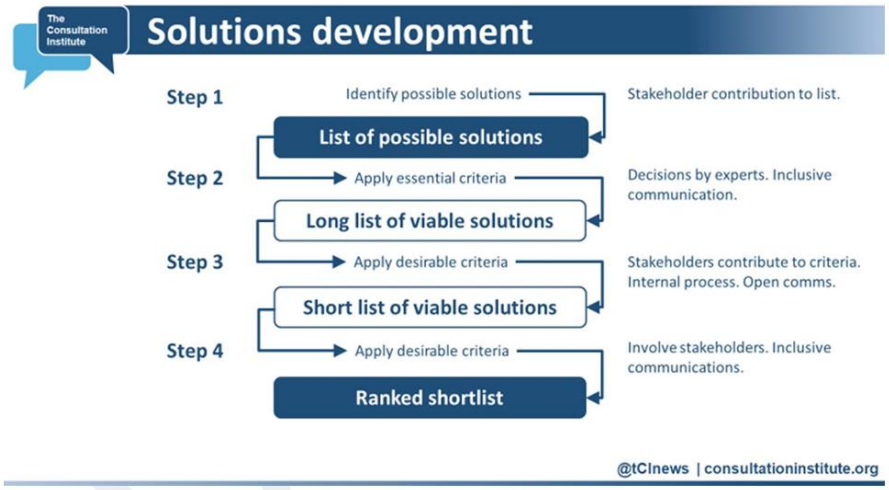
We will commission joined up care for our local population (from health service providers and the voluntary sector) in a way that helps them to feel empowered to care for themselves, prevent illness and remain independent for as long as possible.

Our Goals (how we will get there)

- Commissioning Safe, Accessible, High Quality Health Outcomes
- Seamless Integration & Partnerships
- Empowering Our Staff
- Responsible Use of Resources

What you said was important

Options Development: Process



Step 1

- **October – December 2017**
- Listening Events
- Online Survey
- Bespoke Events
- Clinical Engagement

Step 2

- **January – April 2018**
- Options Development Event
- Options Appraisal Event
- Commissioner & Execs Consideration
- Partner involvement
- Data Modelling

Step 3

- **May 2018**
- Check back on long list
- Expert application of hurdle criteria – must haves
- Options Evaluation – desirables

Step 4

- **June 2018**
- Ranked Shortlist

- Due consideration by Governing Body

High Level Assumptions and Principles

A range of assumptions and principles have been developed which have supported the work to date.

Assumptions

- A UTC needs to be in line with the national principles and standards.
- Step up needs a co-located diagnostic offer (bloods and plain films).
- Fracture clinic needs co-locating with diagnostic and UTC offer.
- Appropriate tier 3 (services that are delivered in eth community) to be provided.
- No tier 4 (Hospital) services in the community.
- An x-ray department would need 10,000 pictures a year to make it viable.
- No NHS capital available to CCG.

Estates Principles

- Assessment of current Estate, ownership & contracts
- Space utilisation
- Capital requirements for change

Finance Principles

- The revised clinical model must demonstrate value for money
- The clinical model must be financially sustainable in the short, medium and longer term
- The clinical model must be financially affordable
- The revised clinical model must align to the financial strategy of moving care between clinical settings, reducing acute bed based care and supporting primary and community care delivery
  The clinical model must be aligned to the STP financial direction of travel

Considerations

Not Commissioned by CCGs

- Drug & Alcohol services
- Smoking cessation
- Sexual health
- Hydrotherapy
- Fitness Support
- Respite care

Can't be provided everywhere

- Diagnostics
- Urgent Treatment Centre
- Maternity / ultrasound

Urgent Care

Reported nationally that multiple urgent care facilities have created additional complexity for patients.

Most urgent care problems are not life threatening and there is an opportunity to deal with them closer to home.

University Hospital of North Midlands (UHNM) has failed to achieve the 95% of patients seen within four hours target. In 2017/18 the Trust have had 387 12 hour trolley breaches, most of which occurred in the latter part of the year; 98 in December 2017 and 272 in January 2018.

Locally the urgent care system has remained under significant and sustained pressure

A&E is often the default choice for many people unsure where to turn when they need urgent care or advice

Locally there is currently a Walk in Centre and a Minor Injuries Unit, both of which need to change to align with the principles of integrated urgent care

Urgent Care

To support people to receive the right urgent care in the right place and at the right time when they have needs that can't be met by a planned care service. The intention is to provide responsive and resilient community urgent care services with the capability to see, treat and complete care in one visit where possible. It is about developing an urgent care system that is easy to navigate and consistent. This may be provided through either an urgent treatment centre or through GP extended access.

Enhanced Primary and Community Care

Aim

To dissolve traditional boundaries between primary care, mental health and community services through the development of a new model of integrated and enhanced community services

Key deliverables

- Sustainable General Practice
- Integrated care teams and localities
- Integrated care hubs

Service Provision

The Integrated Care will provide place based locations for which we can begin to build partnership working and deliver out of hospital care to patients, which is closer to home. The services that will be provided at this level will be developed and will evolve over time

Integrated Care	GP Practice/Primary Care
GP Extended Access	Wound care
Minor Injuries	Anti-coagulation monitoring
Community Clinics	Minor surgery
Diagnostics	Shared care
Outpatient appointments and one stop shop	Physio first
Dementia care	Other enhanced primary care services
Integrated Care team	Phlebotomy
MSK Triage	

Locality Development in Northern Staffordshire

- 10 Localities have been identified across Northern Staffordshire built around networks of practices working collaboratively to provide person centred care.
- These localities have been built around natural groupings of GP practices serving populations of between 30,000-70,000 registered populations.
- Practices are being encouraged to work collaboratively within their localities formally or informally, to provide enhanced primary and community care.
- Integrated care will span community, mental health and social care professionals , along with the voluntary sector, will work with practices and localities to provide coordinated, targeted care based on need.
- Each locality is in a different stage of development with some providing services collaboratively, working closely with integrated care teams and sharing backroom functions.

Integrated Community Teams

Demographic changes have resulted in a greater number of older people living longer with more disability and often with two or more LTCs. The overall aim of the Integrated Care Teams is to improve outcomes for people, create access to better, more integrated care outside of hospital, reduce unnecessary hospital admissions for patients with a frailty and/or LTCs and enable effective working of professionals across Care Hubs with population sizes of 100,000 to 150,000

In Northern Staffordshire there is variance in the needs of the population and the prevalence of long term conditions is comparatively higher than national and regional averages.

The current configuration of long term condition care, is not sustainable in the face of the projected future increase in co-morbidity.

The system is not designed to provide anticipatory care to fully engage and empower patients in their care or to assist patients at their time of crisis.

Traditionally services have been provided by both the Acute and Community Trusts which leads to fragmentation in delivery.

Integrated Community Teams

Our plan is to have Integrated Community Teams incorporating Frail Elderly and LTCs - to support people to receive a high quality, multi-disciplinary, co-ordinated care approach with teams. Where possible these will be in one place, in one building and with one team wrapped around general practice.

Care will encompass both physical and mental health services, closely aligned with the acute trusts and social care with the aim of delivering robust services and pathways to meet the needs of an increasing older population.

Shared Terminology

Now	Definition	Footprint	Population
Integrated Care System	Population health system that aims to tackle the wider determinants of health through a system wide approach across health and social care and the voluntary sector.	Staffordshire STP	1,200,00
Alliance	Geographical groups of providers and commissioners working together to deliver coordinated care through the best use of resources and the removal of artificial organisational boundaries.	3 Alliances Northern Alliance South East Alliance South West Alliance	250,000-600,000
Integrated Community Area	Groups of localities working together on a larger footprint to provide a broader range of services integrating primary care, community social and acute care	10 integrated Community Areas	100,000-150,000 Under development
Locality	Person centred care delivered around networks of practices working with integrated care teams.	23 Localities	30,000-70,000
General Practice	First point of medical contact in the health system, providing high quality, sustainable primary, personal and continuing care to patients and their families.	Current -158 practices Optimum – 118 practices	Current average 7,472* Optimum list size of 10,000*
Integrated Care Team	Multi-disciplinary teams working with practices and localities to provide coordinated, targeted care based on need.	Locality and Integrated Community Area	Service specific

*Weighted list size

Diagnostics

There is a general requirement for community diagnostics (xray and ultrasound) and access to phlebotomy that is community based, due to increasing Long Term Conditions management needs. Community based diagnostics and phlebotomy services distributed geographically and aligned to urgent treatment centres or integrated community teams. For example, X-Ray and Non Obstetric Ultrasound within the community for GP Direct referrals, as a consequence of an Outpatient appointment or as an inpatient of a community hospital.

To date the CCGs have focussed on delivering a range of community diagnostics.

Continue to commission a range of community diagnostic services potentially with some changes in location.

Diagnostics – X-Ray Modelling and Principles

Activity analysis is undertaken to understand where our patients who access x-ray live. This includes reviewing the health inequalities and the patient demographics of these patients.

The activity has been analysed to establish if there are any correlations or relationships that need to be considered, to ensure we are able to identify the impact of any proposals on all patient groups.

The analysis outlines any assumptions that have been made to inform the analysis and modelling. An assumption has been made that demand for x-ray will remain static irrespective as to the location the service will operate from. Therefore the model does not account for any increase or decrease in activity.

To understand how different scenarios being proposed could potentially impact on our patients accessing x-ray services; we have reviewed data and activity to allow us to understand the percentage of patients living with 5 miles of each of the sites and the average travel time to site.

We have then modelled the potential demand at each site in each scenario based on the assumption the patient would use the most local site for their activity.

Dementia Care

Dementia in the UK is still a condition that carries a great deal of fear of stigma attached to it. Research shows that 'it is a condition that people over 55 fear most and with misconceptions still existing that 'nothing can be done' or 'that dementia is a natural part of ageing'.

Services cover the whole spectrum of needs which range from;

- identification of possible memory or cognitive problems to include diagnosis, and continue through to end of life care, to
- specialist dementia services which support people during particular phases of their illness, that require expertise beyond that normally provided by the primary care team.

Stoke on Trent and North Staffordshire diagnosis rates are within the best quartile nationally when measured in the Improvement and Assessment Framework (IAF).

In February 2018, over 70% of all patients with a dementia diagnosis had a care plan which had been reviewed within the last 12 months.

There is some inequity of care currently within specialist dementia services with a Dementia Centre already in place for Stoke on Trent but not for the residents of North Staffordshire.

Dementia Care

Our plan is to continue to provide a mixture of community based services but improve accessibility to Specialist Dementia Services. These will provide specialist, enhanced information, support and advice, a multi-disciplinary assessment of needs in an appropriate setting; and specialist re-ablement/ therapy services. Overall offering a range of specialist professional services in one place.

Planned Care

There are a number of key drivers affecting uptake of planned care services, driven both by supply and demand. Demand for planned care is affected by demographic growth and lifestyle.

Given the pressure that evolving technology and treatments place on tier 4 acute services, combined with greater patient expectations around treatment times. Our intention is to ensure patients have access to services that deliver care at the most appropriate level of need. Looking to free-up capacity within tier 4 services to treat the most sick and complex patients by having a range of tier 3 services to manage less sick patients.

UHNM has struggled to meet the 18 week target which has led to an increase in waiting times for some patients.

To support the management of demand the CCGs have a Choice and Referral and a Clinical Assessment service to reduce the onward referrals to secondary care.

A range of Tier 3 community services are already in place across Stoke on Trent and North Staffordshire.

Planned Care

To provide appropriate tier 3 services in the community providing timely assessment of the needs of a patients presenting with a range of conditions who may otherwise present in a secondary care service. Providing services closer to home but also reducing the pressure on specialist services, and ensuring that patients have access to services that deliver care at the most appropriate level of need.

The intention would be to commission a range of “intermediate” community services; extending the current offering to potentially include urology, cardiology and minor surgery; maintain the range of other services currently provided in the community e.g. rheumatology, pain management.

Bed Profile

The Local Government Association High Impact Change Model (2017) demonstrates how Managing Transfers of Care between hospital and home clearly articulates the benefits to patients through the implementation of D2A.

'Improving support for older people and making discharge easier when the patients is ready to leave hospital, is crucial to manage patient flows in acute hospitals and ultimately to delivering good patient care'. (Public Accounts Committee (2015) – Discharging People from Acute Hospitals.

Historically North Staffordshire and Stoke on Trent CCGs have nearly three times as many community beds per capita than the average, three times as many admissions to community beds.

A bed dependency culture where historically there has been a disproportionate number of community beds, which were too often the default discharge destination.

The consequence of the historic approach to discharge is that the system fills capacity rather than meet need, particularly when the system is under pressure which is often the case.

Bed Base

Our intention is to continue to commission a range of beds to support patients requiring a higher level of care in line with the clinical need of this cohort of patients.

Our system agree modelling indicates that there is a requirement for 132 beds at any one time to support patients who require either beds based assessment or rehabilitation post and acute phase alongside 5300 hours of Home First intermediate care and reablement at any one time.

Understanding the Analysis

To support the generation of options for consideration, the following has been undertaken:

- Demand for current services
- Equality Analysis
- Travel Time Analysis
- Scenario modelling
- Demand modelling

Demand

Since not all data is available to CCGs – it is not possible to accurately predict the demand for all services

Indicative demand has been calculated using the following method:

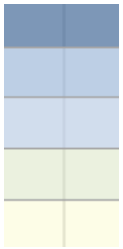
- Where a service offer will be identical, or could move location, existing demand for that service has been used
- Where a service is changing, or the new service does not yet exist in this health economy, demand for similar services has been combined to show the potential ‘pool of demand’ for the new service. This may consist of activity that will not utilise the new service, but will be indicative of the type of activity seen in those services.
- We have not forecast or estimated growth in demand, or attempted to determine the current levels of ‘unknown’ or ‘unmet’ demand in the system.

Maps

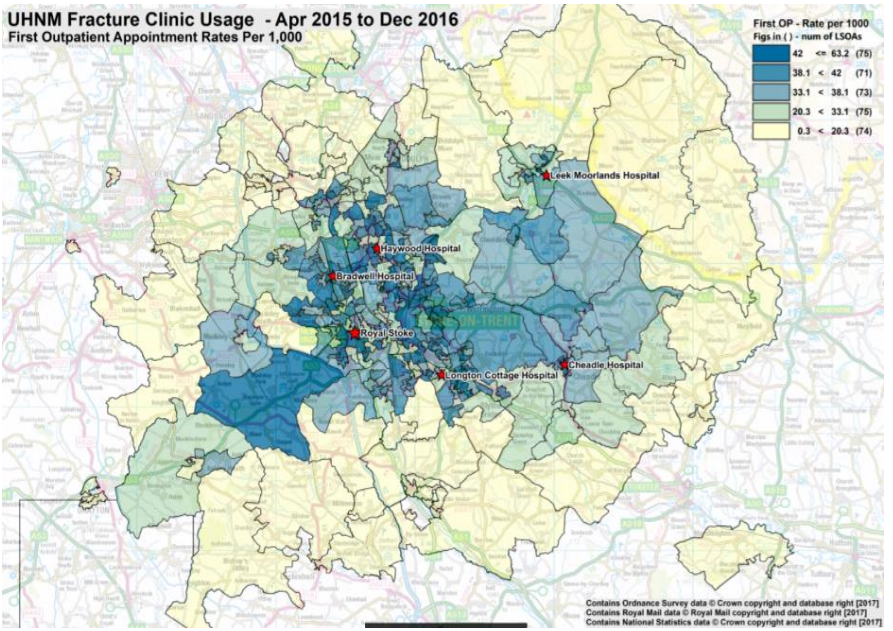
‘Heat Maps’ have been created showing how activity is dispersed throughout the local health economy.

The map is split by Lower layer super output area (see slide 6 for more information) – Each LSOA is coloured depending on the level of activity.

Activity has been split into ‘quintiles’ (i.e. five groups of LSOAs ranked from highest activity rates to lowest.



1st (Highest Usage) Quintile
2nd Quintile
3rd Quintile
4th Quintile
5th (lowest usage) Quintile



Equality analysis

For each community healthcare service, patient activity was identified and grouped by patients' residential location (based on lower super output area - LSOAs).

An average annual activity rate (per 1000 people) was calculated for each area.

These activity rates were used to look for associations between service use and the demographic characteristics of each area. These characteristics included age, ethnicity, religion and deprivation. The 'correlation coefficient' was calculated to numerically determine these associations.

Further important details:

- LSOAs are statistical geographic units containing an average of 1,600 people (minimum 1,000).
- Small area population estimates (SAPE) for mid-2016 (Office for National Statistics) were used for the calculation of activity rates by LSOA. These estimates, by single year of age were used to calculate the proportion of the population over 65, the proportion under 19 and the median age (middle value of the ranked ages of all people) for each LSOA.
- 2011 census data was used to report the proportion of population identified as being from an ethnic minority group and the proportion of population reporting that they have a religion.
- The Index of Multiple Deprivation 2015 (IMD) was used to rank LSOAs from most deprived to least deprived. The IMD score (and rank) is reported for all LSOAs in England and is derived using 37 indicators across 7 domains, such as income, employment, health etc.
- Correlation coefficients were calculated between activity rates and each demographic characteristic to identify associations.
- The slope gradient value from a regression line was used to calculate the average difference in activity rates between the most and least deprived LSOAs.
- ***It is important to note that this analysis is based on neighbourhood (defined using LSOAs) characteristics (age, ethnicity, deprivation etc.) rather than individual patient characteristics.***

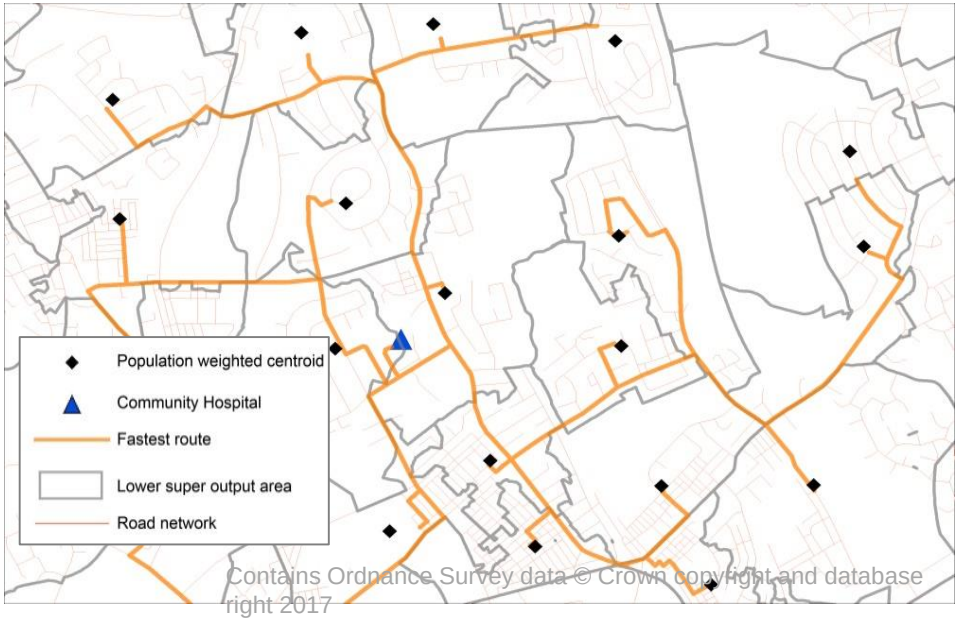
Travel Time Analysis

For each community healthcare service, patient activity was identified and grouped by patients' residential locations (based on lower super output area - LSOAs).

The fastest journey time (in minutes) and shortest distance (in miles) were calculated from each residential location to the postcode location of the closest healthcare setting offering each service and the closest healthcare setting being proposed for each service.

The average journey time for areas with higher levels of activity (higher demand for the service) were compared to those with lower activity (lower demand).

These calculations were used to evaluate the change in journey times for each proposed reconfiguration of a service.



Further important details:

- Residential locations were defined using the 'population weighted centroid' of the lower super output area (LSOA) in which the patient lived.
- LSOAs are statistical geographic units containing an average of 1,600 people (minimum 1,000).
- Ordnance Survey data (OS Roads) was used to map the road network across North Staffordshire and Stoke-on-Trent.
- Journey times were based on average urban and rural road speeds for different road types as published by the Department for Transport (2017).
- Journey times will vary depending on time of day. The typical journey times calculated do not take into account morning or evening peak-time traffic, the effect of roadworks, or time taken at junctions.
- In rural areas, LSOAs are physically larger in size. This means that actual and calculated drive times could vary more in comparison to those in urban areas.

Feedback & Questions?

Next Steps

- 10th May - Check back with you that we have understood your preferences about the services to be provided in each location and refine viable solutions
- w/c 14th May: Experts will apply Must Have's Hurdle criteria to produce shortlist
- 25th May: revisit the criteria that we have discussed at previous events and we will be assisted by the Consultation Institute to evaluate the options developed with you against those criteria.
- 19th June: Extraordinary Governing Body Meeting
- 20th June: Submit PCBC to NHS England
- 5th July: NHS England Panel>>>>> 50 day process