Principles for Developing Acute Reconfiguration Proposals

May 2017

I. 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 acute service transformation.

The Senate can give clinical advice to commissioners and STPs 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 acute transformation and reconfiguration to date, both in the South West and elsewhere across England. Furthermore STP plans across the country show many similarities in proposals for acute and community care, these areas being the most important for STPs along with finance. 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. 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 plans need to be more robust than ever for effective implementation.

Following the development of principles for community reconfiguration in November 2016 it was felt that it would be beneficial to develop some general principles for acute service transformation that CCGs and STPs could refer to when developing models of care. Where principles are addressed this would limit concerns raised at a stage 2 checkpoint prior to review and strengthen overall models of care in line with what clinical senates around the country expect from robust clinical models.

The following principles have been developed based on previous Senate advice, clinical reviews already undertaken or planned in the South West, reviews undertaken by other Clinical Senates, the findings of a literature review considering the evidence for different types of acute reconfiguration and the findings from the a Clinical Senate assembly session on 30th March 2017.

II. 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 acute 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.

III. Evidence for Acute Reconfigurations

TBC following literature review

IV. Detail around Models of Care

a. 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.

b. Use of the acute co-dependencies model

c. 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;

i. Community capacity and capability needs to be taken into account.
ii. Mental health provision must be described.
iii. Clear illustration of acute care networks and links to other acute providers is required.
iv. Clear illustration of the relationship with primary care is key. How GPs realistically link in and any impact upon them or unintended consequences need to be considered.
v. Referral patterns and access particularly for patients with chronic illnesses needs to be factored in.
vi. Transport practicalities can impact the safety of a clinical model if poorly planned.
vii. Robust models will demonstrate patient walk-through outcomes and experiences to test model.

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.

V. Workforce

I. Detailed work must be demonstrated to ensure that the workforce, across the board, 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.

III. According to HEE, 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. Is the workforce affordable?
2. Is that workforce available and have recruitment timelines been considered?
3. What will the workforce look like in terms of skills, diversity and behaviours?
4. What development of upskilling, new roles and new ways of working is needed?
5. What is the implementation plan and timeline for workforce development?

IV. 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.

V. 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.

VI. The impact of any proposed reconfiguration on the ability of a Trust to provide acute care at junior doctor level should be mapped early in the process.

VII. Preservation of teaching and research capabilities is critical and all commissioners should consider building this into future commissioning specifications with all providers.

VI. Communications, Information Management and Technology

a. 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 acute trust networks.

b. Education around new pathways is fundamental to their success and ensuring different services don't open up demand.

VII. Clinical Engagement

a. Widespread clinical engagement and leadership in the service change needs to be described beyond CCG clinical leadership and be demonstrated as a core part of successful reconfiguration.

b. Shared decision making can change patient pathways and impact demand management.

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

d. Ambulance services are not necessarily involved in acute reviews but have an important wider perspective to add and the impact to their service must be factored in.