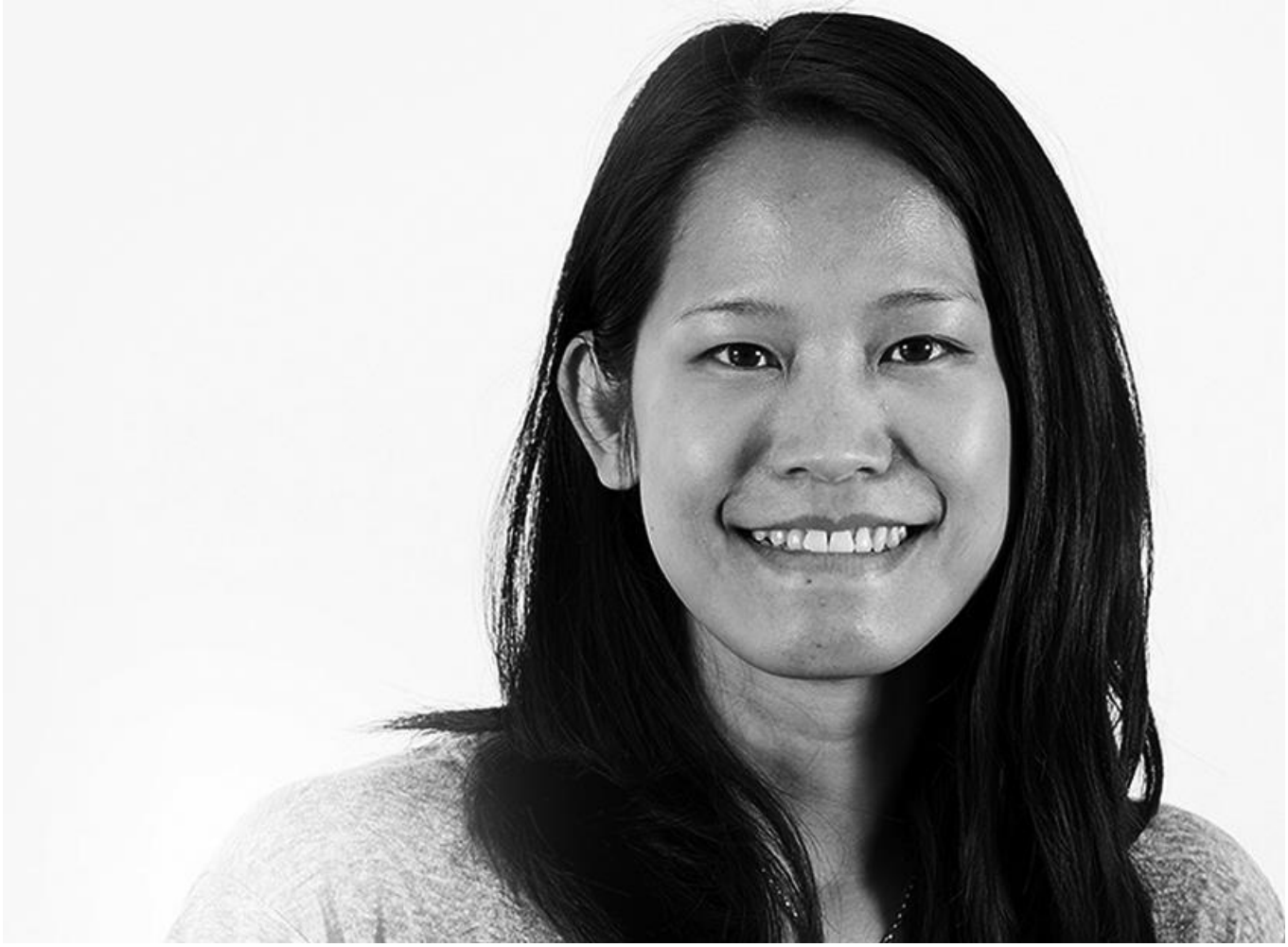
NHS

South West Clinical Senate



South West Clinical Senate: Independent clinical review of community rehabilitation, reablement and recovery services model implementation

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On behalf of South Gloucestershire Clinical Commissioning Group

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Contents

1 Background

South Gloucestershire Clinical Commissioning Group (CCG) sought advice from the South West Clinical Senate regarding its 3Rs (Rehabilitation, Reablement and Recovery) implementation plans, based on the model of care being developed by Sirona Healthcare and North Bristol Trust (NBT). It was agreed that since the CCG had already sought and received clinical advice from the South West Strategic Clinical Network's rehabilitation programme on the model of care, a formal NHS England 'stage 2' clinical review by the Senate would not be appropriate.

The Senate therefore agreed to provide advice to the CCG about the 3R model implementation plans. This would be separate to and independent of the NHS England assurance process for large scale change but would provide an independent clinical view of the plans for implementing the agreed model of care.

The aim was to provide an independent clinical review of the implementation plan for the proposed model of community rehabilitation, reablement and recovery service provision in South Gloucestershire. The main role of the review panel was to discuss and comment on whether the proposed model of care and its plan for implementation is in line with national best practice and, where necessary, advise on what is missing or requires amendment.

2 Executive Summary

Following sign off of the Terms of Reference for the review with the CCG, the Senate convened an out of area independent clinical review panel which initially met in November 2015. The panel were given information provided by the CCG describing the model of care which they reviewed and scored.

Based on the information given to them, the panel provided 8 summary recommendations detailed in full in section 5.2 of this report and advised that;

- Although the intention and direction is right, the model does not currently describe acceptable service provision.

- Significant further work is required to add detail to the model, with particular clarity required around the following;

  - Financial model
  - Number of beds and move to focus on community services
  - Workforce training and planning
  - Patient pathways and links to specialisms
  - Sustainability

It was subsequently agreed with the CCG that the Clinical Senate would convene a further 'critical friend' meeting held by the Chair of the review panel and one of the external review clinicians as an opportunity for the CCG and service provider to share additional information and clarify details about the service model.

This took place with the CCG and Sirona in April 2016 and proved extremely helpful in order to provide the history and narrative that a 'read and review' of documents could not give in its entirety.

The CCG provided a response to the initial recommendations and since the original review meeting in November 2015, sufficient time had elapsed to be able to see how phase one which rolled out in October 2015 was progressing. The CCG commented that at the time of the panel it was undertaking service procurement and consequently much of the procurement documentation answered specific service questions rather than give a service model overview.

It was noted that the initial review focus requested was of phase two (the bedded element) of the 3R service model, and that therefore phase 1 (the bedded equivalents) was not detailed in information provided to the Senate. However for the Senate panels' review and analysis of the model of care for the 3Rs it was important to understand beds in the context of bedded equivalents and the whole 3Rs strategy and model.

The critical friend panel, following its April meeting was confident, given additional information, that the 3R model being implemented is robust. Much clearer information, particularly around total numbers of beds and non-bedded support in the context of the whole model was provided and discussed. Each of the 8 summary recommendations was addressed as detailed in section 6.5 of this report.

Some areas for further work specifically around workforce development and mental health provision were identified. The CCG is also encouraged to consider the wider context of developing community services and ensure that this particular model of care benefits from Sirona successes and initiatives elsewhere. Some shared learning with Wessex Clinical Network was also agreed. The importance of documentation in comprehensively describing a model of care to external parties was also noted.

The links being established between the acute and community services was commended as very promising and that the service should continue with this direction of travel.

3 The Review Panel

The independent review panel was convened by the South West Clinical Senate to bring together a range of clinicians with significant experience of rehabilitation and recovery. Panel members are senior leaders within their professions and their health communities of practice. Dr Phil Yates, Chair of the South West Clinical Senate, acted as the Chair of the Review Panel and facilitated the discussion but did not score the proposals. Panel member biographies are provided in Appendix 3.

Prior to the panel meeting, clear Terms of Reference (see appendix 1) were developed and agreed with South Gloucestershire CCG outlining the methodology, process and timeline for the review. Panel members were required to declare any conflicts of interest. None were declared.

Name	Profession/Job title	Representing Senate area	Role
Dr Phil Yates	Chair, SW Clinical Senate	South West	Chair
Hayden Kirk	Consultant Physiotherapist & Clinical Director	Wessex	Panel Member
Jane Petty	Physiotherapist	Sheffield	Panel member
Raman Sharma	Superintendent Pharmacist	Yorkshire and Humber	Panel member
Vimal Sriram	Occupational Therapist	London	Panel member
Dr Graham Spratt	Consultant Clinical Psychologist	Greater Manchester, Lancashire and South Cumbria Clinical Senate	Panel member
Dr Jane Williams	Clinical Programme Director for Integrated Rehab	Wessex	Panel member
Ruth Williams	Clinical Directorate Lead	West Midlands	Panel member
Sunita Berry	Associate Director, SW SCN & Senate	South West	In attendance

4 Methodology

Each panel member was provided with a comprehensive pack (see appendix 5) in order to review and score the proposed model. Panel members were also given Sirona and NBT's second stage response (appendix 5.1) which included detailed answers to 6 specific questions regarding the implementation of its proposed model of care. KPIs were also provided.

Each panel member individually reviewed the proposal and KPIs, and were given eight questions to consider. The panel then held a final face to face meeting on 9th November 2015 chaired by the Chair of the South West Clinical Senate to discuss and consolidate views into a single moderated response.

Further comprehensive detail about the scoring methodology and the panel's commentary can be found in the initial report.

5 Initial Recommendations

5.1 Clinical Senate Chair Summary

The South West Clinical Senate brought together an independent, out of area review panel to consider the plans South Gloucestershire Clinical Commissioning Group set out to implement a model of care for rehabilitation, reablement and recovery. The CCG had had extensive engagement with stakeholders including patients and the public.

The process for review initially included two steps:

- Panel members individually reviewing the available papers and scoring a list of 8 evaluation questions which had been sent out in advance.

- A full panel meeting during which the participants had the opportunity to discuss the proposals with other panel members and to advise the Chair, Dr Phil Yates, of their recommendations and to produce a moderated score. This panel meeting was held on Monday, 9th November 2015.

The panel held a productive and high level discussion. Panel members' individual scores were largely commensurate with one another however the final scores of the service model were ultimately low. The panel did feel that the overall sentiment behind the model was good for patients and it provided interoperability with community care through Sirona. The energy and effort on governance with CEO engagement as well as the anticipatory personalised care plan were commended.

Based on the information given to them, the Panel advised that;

- Although the intention and direction is right, the model does not currently describe acceptable service provision.

- Significant further work is required to add detail to the model, with particular clarity required around the following;

    - Financial model
    - Number of beds and move to focus on community services
    - Workforce training and planning
    - Patient pathways and links to specialisms
    - Sustainability

The draft report from the clinical senate in November 2015 outlined 8 summary recommendations for the CCG to follow up.

It was subsequently agreed with the CCG that the Clinical Senate would convene a further 'critical friend' meeting held by the Chair of the review panel and one of the external review clinicians to go over the recommendations and as an opportunity for the CCG and service provider to share additional information and clarify details about the service model. It was discussed that the CCG felt that the recommendations were already addressed within their model but that the detail had not been evident in the information provided to the panel.

5.2 Initial Summary Recommendations

1. The CCG are asked to reconsider the number of beds that are required. The panel felt that the number of beds outlined in the proposals are too many for the population and may threaten the financial viability of the endeavour.

2. The plans should demonstrate the ability to deliver services 7 days a week

and include a greater focus on ‘pull models’ to enable patients to return to their usual residence.

3. Detailed service plans should be developed demonstrating partnership with agencies such as the ambulance service, voluntary sector and primary care to support patients in their homes and avoid admission to hospital.

4. The responsiveness of services should be clearly articulated in the KPIs through effective use of response times. It is likely to aid flow through the pathway particularly if transitions such as step up or step down are managed through careful care planning and described clearly in standing operating procedures.

5. A clear workforce plan including a review of skill mix within all participating agencies should be developed to support delivery.

6. Whilst services for dementia are reasonably well described, provisions for broader mental health services need further development.

7. End of life support for patients and their carers, including for patients in nursing homes in order to reduce the pressure on beds should be described.

8. A single point of access is recommended.

6 Critical Friend Meeting

A critical friend meeting was subsequently convened on 21st April 2016 which brought together the CCG, service provider Sirona, the Senate panel chair and one of the external clinical panel members.

Name	Profession/Job title
Dr Phil Yates	Chair, SW Clinical Senate
Jenny Theed	Sirona, Lead Provider
Dr Jane Williams	Clinical Programme Director for Integrated Rehab (Southern Health) Panel member acting as Critical Friend
Cathy Daffada	Sirona, Lead Provider
Ben Bennett	Programme Director – Strategy & Development, CCG
Dr Jonathan Evans	GP, South Gloucester – Clinical Lead for 3Rs, LTC and End of Life
Guy Stenson	Director of partnerships and integration, CCG
Ellie Devine	Senate Manager South West Clinical Senate

6.1 Scene setting

The main purpose of the meeting was to go over the summary recommendations from the initial review report and provide an opportunity for the CCG and service provider to fill in gaps and add in detail the panel weren’t originally provided and therefore couldn’t comment on. It was felt by the CCG that almost all of the recommendations had always been in hand but that the information to demonstrate

this wasn't clearly laid out in the original documentation provided to the Senate for its panel.

(*Note: The Critical Friend meeting was originally due to convene in January but had to be re-arranged due to unforeseen personal circumstances.)

6.2 Update to the Draft Report

The Critical Friend session was used as a clarification meeting to go through the recommendations, the response to them provided by the CCG and to discuss the current status of the service since the original clinical review was undertaken in 2015 and a significant amount of time had elapsed.

It was noted that at the time of the panel, the CCG was undertaking service procurement and consequently much of the procurement documentation answered specific service questions rather than give a service model overview.

Prior to the meeting the following documents were shared and are also attached as appendices;

1. **CCG Response to initial Draft Report**
2. **Additional Commentary - CCG**
3. **Case Studies of Patients in Services Now and Care Post Redesign x 3**
4. **Evaluation Plan**
5. **Service Specification – End of Life Care**
6. **NAIC 2015 – Provider Dashboard Report**
7. **Agenda – Critical Friend Meeting**
8. **Initial Senate Report**

It was noted that initial review focus requested was of phase two (the bedded element) of the 3R service model, and that therefore phase 1 (the bedded equivalents) was not detailed in information provided to the Senate. However for the Senate panels' review and analysis of the model of care for the 3Rs it was important to understand beds in the context of bedded equivalents and the whole 3Rs strategy and model. Whilst the phasing helped delineate 'how' a new model would be implemented the full picture was needed to consider the clinical model holistically.

Meeting with the key clinicians from the CCG proved extremely helpful in order to provide the history and narrative through questions and answers that a 'read and review' of documents could not give in its entirety.

6.3 Overview of the Clinical Model

The group had an in depth and frank clinical discussion about the current service and worked through the key areas of concern identified in the draft report.

A background summary was provided by the CCG describing how they were originally seeking a partner to deliver change to community services in an environment where acute trusts did not want to deliver the services. Sirona was a provider with an excellent track record in B&NES. They were subsequently set up as a long term partner with a 5 plus 2 year contract with the CCG. The 3R work was described as having solid foundations with much work carried out prior to the

implementation of the model of care under review. The original CCG Chair Stephen Illingworth led the rehabilitation work stream which included conducting a large scale evidence based review and clinical audit of rehabilitation beds across the patch that gave a good grounding to establish a clinically led model of care to be delivered with a phased approach.

Since the original review meeting in November 2015, sufficient time had elapsed to be able to see how phase one which rolled out in October 2015 was progressing. The Phase One bid (bedded equivalents) focused on better aligning primary and community services, managing complex and unstable patients and aligning services around clusters of patients. This was based on Sirona's B&NES model to provide integrated health and social care services around patients. The contract was agreed in April 2014. Shortly after this Frenchay hospital closed. Modelled around a Sheffield pilot the discharge to assess model was then taken forward and developed with NBT and the local authority. A valuable test and learn pilot was carried out in January 2015 which saw significant benefits to the model and phase 1 was rolled out and has since seen a big increase in rehab at home services for patients. It was discussed however how the model was not just about rehabilitation but reablement and recovery too with the whole spectrum of phase one and two care offering different solutions for patients.

Phase Two focuses on the bedded element of the 3R programme. The CCG confirmed that a total of 87 beds which incorporate 44 reablement beds are currently delivered via;

- 38 at Southmead Hospital on Elgar Ward
- 20 at Thornbury
- 29 across 5 nursing homes

6.4 Panel Discussion Notes

The CF panel asked about access to geriatricians as NBT are struggling to recruit. Joint ward rounds are undertaken at Thornbury and Elgar with access to the Geriatrician of the Day (GOD) phone. They are also looking at expansion of a community role for specialist generalists and care of the elderly physicians. Supported by the roll out of Phase One the service has the capacity to move 30 people per week out of NBT to their own home. They are reducing length of stay by 3 days at NBT. The panel discussed that as the service is consolidated and benefits are seen that more substantial movement of funds to reflect patient movement will need to be agreed in the future.

Sirona co-ordinates the discharge for all patients including in-reach and GP support with 79% of discharges to patients' own homes and LOS at 29-30 days. Sirona has successfully ring-fenced beds for cognitive deterioration/impairment. It was discussed that the opportunity to go home rather than into a permanent placement from the outset lowers the overall number of permanent places required. Once a patient goes into a permanent placement it can be difficult to come out again. Discharge to assess also allows flexibility to match patients to different homes. Reasons for readmission are looked at weekly and feed into management plans to help prevent readmission.

The elderly mobility score is used on admit and discharge in addition to a wellbeing score, and a frailty team score is included in the phase 2 outcome measures as well as patient feedback surveys. Weekly meetings take place at all practices to problem-solve around the most vulnerable patients. Age Concern are linked in and an active ageing service and health visitors for older people is slowly taking off. Sirona is also working with dementia matters to get butterfly accreditation. A frailty screening service is currently being delivered as a pilot in some but not all practices. Frailty is managed by GP referral but there is also an active ageing 80-84 group (ages 80-84) which actively identity's patients.

Sirona's supported approach to training with 'every contact counts' was discussed. In Sirona's own initial baseline audit of staff they scored 8 out of 10. Sirona focus on health coaching and supported self-management to support staff purpose, morale and resilience.

It was noted that the CoE consultants at NBT have reported that they are very happy with how things are progressing via a therapy and nursing driven service with medical support available. Although there are ongoing tensions in the overall system and significant financial challenges the daily service interaction is very functional and positive for patients. Rotational posts are being considered between acute and therapy settings for both therapy and medical staff.

Team MDTs are held but there are currently no consultant therapists or consultant nurse practitioner posts. The group discussed the importance of developing community staff. Sirona described its commitment to the non-medical pathway. It was felt that the gap between the acute sector and the community was starting to close and that future working with geriatric teams to develop non-medical consultant roles with clearly understood roles and responsibilities is needed. Sirona noted that they also have social worker input to MDTs which was initially felt to be impossible as well as good engagement with the head of social services.

GP input to the model was discussed. It was felt that although most GPs would not necessarily be fully aware of discharge to assess they would be seeing different outcomes.

Each patient MDT cluster has a ward clerk where a formal agenda is set with agreed patients and outcomes minuted on patient records. They have 6 clusters. The next step is to work to an integrated team model although the plan is not yet to have joint funding.

In terms of governance the Better Care Fund overarches many CCG work programmes and links to comprehensive governance processes as well as Public Health, Social Care and so on. JE Chairs the BCF steering group which helps to ensure the model is aligned.

In terms of developments in digital healthcare, wards are currently paper based however Sirona are developing a single assessment form from acute trusts and referral to EMIS for community based units and rehab teams. Integrated records are an aim across the board linked in via the CCG connecting care portal.

6.5 Response to Recommendations

Along with the CCG two response documents (appendices 1 and 2) to the panel's initial recommendations, the CF panel meeting discussion helped to clarify many of the points raised in the initial senate panel report and also specifically address the 8 summary recommendations for which more comprehensive information is provided in appendices 1 and 2;

1. Beds

The whole model incorporating both phases is not just a bed led model but has beds as a platform for delivering the majority of care in a home setting. The number of beds is anticipated to reduce but was set at 87 initially with the intention of having scalability to switch use of beds. The model is also set in the context of an ambitious reduction in beds at NBT where beds have been an issue since the opening of the new Brunel building in 2014. Community services need to mature to support this acute reduction in addition to resolving internal factors.

The service is set up to be funded within the current envelope. However finance is tied up in acute contracts which will need to be considered in future years to release funds for community. Some non -recurring investment has gone into the test and learn approach. South Gloucestershire CCG is the sixth lowest funded in the country and the acute trust has the complexity of delivering to three commissioners. Confidence needs to be provided going forward that if money is moved, patients and activity will be moved.

2. 7 Days a Week and Pull Models

Discharge to assess is itself a pull model. The rehab at home services are 7 days a week. Bedded services are led by the acute trust but can admit 7 days. Discharge for 3R patients is often safer at weekends.

3. Partnership agencies and hospital avoidance

The 3R work is a sub-set of the System Partnership Project which brings together SWAFT, OOH, 111, Trusts, neighbouring trusts and commissioners as well as mental health. 3Rs has fed into the ambulance DOS and the ambulance service has also been working on a community falls service.

4. KPIs

KPIs were being finalised for phase 2 with a focus on service user and carer feedback. Live review is currently ongoing with a test and learn approach. A co-designed framework has been set up for evaluation and monitoring with the two providers and two commissioners as well as sessions with service users and carers. This will go into the service specification for the contract they are just entering with more integrated metrics measuring the whole model.

5. Workforce plan

There is a workforce plan in place for phase 1 and a separate plan for phase 2 which the panel discussed.

6. Dementia and Mental Health

Staff attached to practices and clusters will support Mental Health requirements at the moment. Sirona has a Head of Mental Health services

and all staff have parity of esteem training. A vocational hub in Keynsham has just launched and will roll out also in South Gloucestershire. There is close working as an organisation with the Avon and Wiltshire Partnership. Sirona also provide an LD service in South Gloucestershire with good transition set up for children and adults.

7. End of Life
The service specification for End of Life care is provided in appendix 5. This is set up as a separate project to the 3Rs work but also led by Sirona.

8. A single point of access
Sirona became part of a single point of access in September 2015.

6.6 Next Steps for the Model of Care

Phase 1 and phase 2 will be brought together in the 16-17 contracts which include the new model of care. Business cases for the new buildings will be signed off during the Summer of 2016. The Sirona board have committed investment with the development partner on the land which is owned by NBT.
The development is expected to be signed off by the autumn with work beginning on site by March 2017 although some commercial issues are anticipated. The model of care itself is considered live with ongoing refinement and improvement and subsequent transfer to new settings. The focus of phase 2 is on new facilities but the model of care goes beyond buildings and beds.
Social care beds will be co-located on each site with extra care housing making the model of care easier to deliver. A HCA grant has been sought and the two centres for South Gloucestershire will be integrated. An impact assessment for the model of care will be carried out once new builds and integration are complete

7 Final Advice and Recommendations

The purpose of this review was to provide an independent clinical review of the implementation plan for the proposed model of community rehabilitation, reablement and recovery service provision in South Gloucestershire, commenting on whether the proposed model of care and its plan for implementation is in line with national best practice and, where necessary, advise on what is missing or requires amendment.

Following the further information provided at the Critical Friend meeting the South West Clinical Senate Chair and critical friend Dr Jane Williams were satisfied that the original concerns identified in the draft report had been understood and responded to sufficiently. Much clearer information especially around total number of beds and non-bedded support in the context of the whole model was provided and discussed at the meeting. The additional information provided was extremely helpful as was the ability to discuss the model of care already put in place to date. Predominantly the concerns of the panel were as a result of the ability to be able to lay out the model of care clearly and comprehensively to external clinicians that had not been involved in the set-up of the service. The CF panel noted that at the time of the review in November 2015 the service was going through procurement and as such documents relating to procurement were shared to illustrate the model of care. Being able to

easily and adequately describe your model of care is crucial and lays the foundations for future success, relationship building and review.

The Critical Friend Panel was confident, given additional information, that the 3R model being implemented is robust. Some areas for further work were identified as follows;

1. It will be important to maintain a clear focus on workforce development to support the ongoing successful delivery of the 3R model. External support may be required. The emphasis on workforce reconfiguration to develop community services to support discharge from hospital must also feed into the BNSSG footprint plans.

2. Mental Health provision requires further work and should be fully incorporated into system flow work.

3. The new 3R model is being delivered in the context of relatively immature services and processes surrounding it such as End of Life and the single point of access, which should be taken into account when managing risks.

4. Sirona has an excellent track record however there is a risk of using Sirona work elsewhere to support the 3R phase 2 roll out when workforce development for example or mental health services need to be included and evident in the phase 2 plans for South Gloucestershire's 3R model of care.

5. The liaison being established between the acute and community is very promising and the service should continue with this direction of travel.

Finally, it was agreed that Jonathan Evans and Jane Williams would share learning with each other following the CF panel to pick up some of the issues discussed; for example JW agreed to share information about nurse specialists and work carried out by the Wessex SCN.

It was also agreed that there had been useful learning for both parties via the review process; both in the value of meeting with clinical delivery teams face to face as well as the ability to clearly lay out your full model of care via one or two documents that clearly reference and documented the context, delivery mechanisms, clinical case for change and governance.

8 Next Steps

This report will be signed off by the South West Clinical Senate Council and original review panel in early June. Subsequently to this it will be formally given to South Gloucestershire CCG to take to their governing body prior to publication.

9 Appendices

1. **CCG Response to initial Draft Report**


SG CCG & C response to the SWC

2. **Additional Commentary – CCG**


Additional Commentary for April

3. **Case Studies of Patients in Services Now and Care Post Redesign x 3**


Community Nursing and IV casestudy- Ma


D to A pathway 1 case studies- March 2


D To A pathway 2 CRBT Case Studies- M

4. **Evaluation Plan**


Evaluation Plan v0.4.doc

5. **Service Specification – End of Life Care**


Service Specification - SG EoLC Coordinatic

6. **NAIC 2015 – Provider Dashboard Report**


NAIC_PROV065.pdf

7. **Agenda – Critical Friend Meeting**


Agenda 21st April 'Critical Friend' Meetir

8. **Initial Senate Report**


17.11.15 Draft Report - final version

9. **Terms of Reference**


3 Terms of reference.pdf