North Derbyshire JoinedUpCare

Community Hubs
Pre Consultation Business Case
Stage 4
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## List of acronyms / abbreviations

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<th>Abbreviation/ Acronym</th>
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<tr>
<td>A&amp;E</td>
<td>Accident &amp; Emergency</td>
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<tr>
<td>AHP</td>
<td>Allied Health Professional</td>
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<tr>
<td>ANP</td>
<td>Advanced Nurse Practitioner</td>
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<tr>
<td>BPSD</td>
<td>Behavioural or Psychological Symptoms in Dementia</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
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<tr>
<td>CPN</td>
<td>Clinical Psychiatric Nurse</td>
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<td>CPRG</td>
<td>Clinical and Professional Reference Group</td>
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<td>CRH</td>
<td>Chesterfield Royal Hospital</td>
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<tr>
<td>CST</td>
<td>Cognitive Stimulation Therapy</td>
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<td>DCC</td>
<td>Derbyshire County Council</td>
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<td>DCHS</td>
<td>Derbyshire Community Healthcare Services FT</td>
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<td>DRRT</td>
<td>Dementia Rapid Response Team</td>
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<tr>
<td>ECIP</td>
<td>Emergency Care Improvement Programme</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>FRC</td>
<td>Functional Residual Capacity</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>ICS</td>
<td>Integrated Care Service</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<td>LWWD</td>
<td>Living Well With Dementia</td>
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<td>MAS</td>
<td>Memory Assessment Service</td>
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<td>MIU</td>
<td>Minor Injury Unit</td>
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<td>ND</td>
<td>North Derbyshire</td>
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<td>OOH</td>
<td>Out of Hours</td>
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<td>OPMH</td>
<td>Older Persons Mental Health</td>
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<td>OT</td>
<td>Occupational Therapist</td>
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<td>PCBC</td>
<td>Pre-Consultation Business Case</td>
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<td>SRG</td>
<td>System Resilience Group</td>
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<td>UCC</td>
<td>Urgent Care Centre</td>
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<tr>
<td>UEC</td>
<td>Urgent &amp; Emergency Care</td>
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<tr>
<td>UECN</td>
<td>Urgent and Emergency Care Network</td>
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<td>UoP</td>
<td>Unit of Planning</td>
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<td>WTE</td>
<td>Whole Time Equivalent</td>
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Executive Summary – introduction and context

This Pre-Consultation Business Case (PCBC) sets out the context, case for change and proposed future models of care that contribute to the development of ‘Community Hubs’ – through which joined up community based services will be delivered across North Derbyshire.

Context

Community Hubs are a critical element of the North Derbyshire system plan to improve how care is provided for the people of North Derbyshire. Fundamentally, the aim of the whole system plan is to keep people:

• Safe & healthy – free from crisis and exacerbation.
• At home – out of social and health care beds.
• Independent – managing with minimum support.

... which will be founded on building strong, vibrant communities.

‘Community Hubs’ is also the name of the work stream which is co-ordinating the development of the hubs. Crucially, it will link with, and be dependent upon, other work to develop joined up care services.

The development of Community Hubs should be seen as a ‘progressive process’ that will evolve over the coming years as the needs and expectations of people develop; this is not just a one off ‘project’.

To ensure the proposed models and options were understood and owned by the public, clinicians and professionals and that they were supported by sound clinical evidence and opinion, over the last 12 months, the work to develop Community Hubs has been supported by a widespread engagement programme.

The proposed service changes are the result of an evaluation process that was designed to enable the Community Hubs workstream to consider, in a structured way, alternative models of care to those that currently exist, the options for delivering these and the preferred way forward for the system.

What is covered by the PCBC

Given the broad scale and scope of the proposed changes, the PCBC has been reviewed and considered by Commissioner and Provider Boards in stages.

Stage 1 focused on Specialist Older Persons Mental Health (OPMH) and community bedded care.

Stage 2 added Urgent Access to Care and Learning Disabilities together with the impact on other community services and the sites from which they are delivered.

Stage 3 (the full PCBC) adds Dementia Day Unit services, revises the approach to urgent access to care and proposes site rationalisations (based on the implications of the other proposed changes).

In addition, it describes:

• How we have engaged with stakeholders (including the public)
• The processes used to develop the proposals (including option evaluation)
• Commissioning, contracting and financial arrangements
• Potential implementation timeline and considerations
• Workforce planning and development
• Risks and mitigations
• An overview of the consultation messages and consultation plan
Executive Summary – Specialist Older Persons Mental Health (OPMH)

Specialist OPMH
Caring for older people with moderate to severe dementia in times of crisis.

Case for Change:
The current model of care can be traumatic for people as well as being clinically and financially unsustainable given the forecast growth in demand.

- **Improving the quality of care**: Hospitalisation of people with dementia has negative impacts on both physical and mental health including: i) greater cognitive impairment as a result of taking people out of their usual place of residence; ii) decompensation due to reducing levels of activity – which sometimes results in a return to home becoming impossible.

- **Improving the sustainability of the workforce**: The current workforce (nursing in particular) is insufficient to meet the forecast increase in OPMH inpatient activity across the 3 current units, therefore increasing the risk of failing to meet safe staffing guidance.

- **Improving service effectiveness and efficiency**: Health spend across all North Derbyshire OPMH services is currently £3.3 to £1 inpatient : community. North Derbyshire remains behind the national trend for moving to community based interventions. Both commissioners and providers believe this is a key reason for failing to consistently meet the Quality Outcomes for People with Dementia.

Proposed future models:
The proposed service change would see half of the people currently treated in an inpatient hospital being instead treated at home by a specialist community based team, known as a Dementia Rapid Response Team (DRRT).

Specialist OPMH beds would still be provided for those with the most severe symptoms, however these would be fewer in number and consolidated at one ‘centre of excellence’.

Impact and implications:

**Costs:**
The baseline costs of providing bed based care in the 3 OPMH units is c.£8.7m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to c. £10.6m.

The proposed service model would cost an estimated £9.2m and there is opportunity to reduce this by up to c.£1m if the system is able to rationalise ‘stranded’ costs.

**Workforce:**
Whilst overall the proposals would result in a small (c. 7%) reduction in the overall number of health staff (WTEs), there would be a significant change in the skill mix required (fewer nurses but more specialists and therapists).

There would also be an increase in the numbers of additional social care workers to support people being cared for at home instead of in hospital.

**Access:**
Analysis of travel distance for people treated in inpatient care demonstrates that due to having a single specialist centre, for some people, this will mean they are cared for a longer distance from home.

Overall however, because more people will be cared for at home, the total travel will be significantly reduced (c. 30%).

**Implementation:**
The proposal would see a reduction in the number of OPMH beds from 50 in 2014/15 to 30 by 2018 provided in a single centre of excellence at Walton. During this time, alternative care to support people at home will be developed through the Dementia Rapid Response Team.

Moving from ward based care to a community based care presents significant workforce development challenges. One of the key aims will be to redeploy existing staff wherever possible. Transitional costs including training and any redundancy costs are still to be defined.

**Overall, the proposed changes would see more people with dementia cared for at home, thus reducing the demand for Specialist OPMH beds to 30.**

This would be beneficial to patients given the negative impacts, both physical and mental, that can occur during inpatient care; improving the quality of care provided.

It would also deliver an annual cost avoidance benefit of £1.4m, with the potential for up to £1m more through rationalising stranded costs.
Executive Summary – OPMH Dementia Day Unit Services

OPMH Dementia Day Unit Services
Services that support people generally with low to medium levels of clinical risk associated with their dementia.

Case for Change:
Although those attending day hospitals clearly benefit, there are some issues with the delivery of the services from central, ‘bricks and mortar’ sites

- **Improving the quality of care:** Specific specialist assessment is better made in the person’s own home environment; care and treatment within the local community offers better outcomes for more people; ‘all day’ day care can make people with dementia anxious about a return home.
- **Improving access to services:** Many people are reluctant and worried to travel to the central day hospital; often the person may be too unwell to travel to the central site, or is unable to tolerate being with a large group of other people – meaning that it doesn’t provide an effective alternative to hospital admission.
- **Improving take up of services:** The Living Well With Dementia (LWWD) programme is vital to the progress of people newly diagnosed with dementia – currently less than a third of people diagnosed with dementia through MAS take up the offer of the LWWD programme.

Proposed future models:
- Organic assessment would be provided by a set of services aligned to the individual patient needs and delivered within the person’s own home.
- The proposed LWWD services would provide enhanced services within local communities to support three times as many people as current services, soon after initial dementia diagnosis.
- In addition, new Community Support Team (CST) services would be established to further support people with dementia as their condition progresses.
- The vital role of carers is fully recognised, as is the need to provide effective support for them. The proposed model will provide at least the equivalent support to the current model through a combination of means aligned to the individual and carers needs.
  - Functional illness support would be provided in a more integrated and community based way through increased capacity in the Integrated Care Service (ICS) and Community Mental Health Teams (CMHT).

Impact and implications:

**Costs:**
- The baseline costs of providing Day Unit services for c.550 people in the 3 Day Units is c.E1.9m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to c. £2.3m.
- The proposed service model would cost an estimated £1.5m and there is opportunity to further reduce this by up to c.£0.4m if the system is able to rationalise the ‘stranded’ costs.

**Workforce:**
- The proposals suggest a significant reduction in overall number of health staff (WTEs) supporting equivalent services; this does not take account of the significant increases in the community based teams (DRRT and ICS) proposed elsewhere in the PCBC, who would be providing a significant proportion of the proposed services.

**Access:**
- Care will be provide either within people’s homes or in centres within local communities. Consequently, people will need to travel less when they are attending group programmes and not at all when supported in their own homes.

**Implementation:**
- The proposed model of care would see the closure of the Dementia Day Units in Walton, Newholme & Bolsover.
- The impact and implications for those sites is considered elsewhere within the PCBC.

*Overall, the proposed changes would see services currently delivered through the Dementia Day Units instead provided through a combination of services either within people’s homes or from sites within their communities.*

*These services would also be better integrated with other community based services including ICS, DRRT and CMHT.*

*As a result, Dementia Day Units at Walton, Newholme and Bolsover would no longer be required and would close.*
Executive Summary – Community bedded care

Community bedded care
Elderly people who require rehabilitation and reablement support, following an illness or injury, are often admitted to a community hospital bed, particularly following an acute hospital episode.

Case for Change:
The current model of care can cause ‘decompensation’ for elderly patients as well as being clinically and financially unsustainable:
• **Improving the quality of care**: Caring for older people in a hospital bed can be detrimental to such an extent that it can outweigh the benefit of the care received, due to the extent of physical, psychological, cognitive and social ‘deconditioning’.
• **Improving the sustainability of the workforce**: The majority of community beds are provided from single stand alone wards across 5 community hospitals which face continual workforce resilience challenges.
• **Improving service effectiveness and efficiency**: The mind set of health and social care is still too often hospital bed first; although most people want to remain in their own home whenever possible. They are often cared for at ‘levels of care’ which are higher than required to meet their needs. Not only is this not want most people want, it is also resource inefficient and increase the risk of iatrogenic (health and care induced) harm.

Proposed future models:
The default care setting for all patients should be the place they call home as this can significantly improve the quality of care received (due to a reduced likelihood of decompensation).

The proposed service change would see half of those people who currently receive reablement and rehabilitation support in a community hospital bed, instead cared for at home by a community based service, known as an Integrated Care Service (ICS).

The remainder will be cared for in a smaller number of local Intermediate Care Beds (also supported by ICS) or in higher intensity Specialist Rehabilitation Beds.

Impact and implications:
Costs:
The baseline costs of providing bed based care in the Community Hospitals and Intermediate Care beds is £13.4m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to £16.3m.

The proposed service model would cost an estimated £10.0m plus £1.7m of stranded costs (£11.7m total). There is opportunity to reduce this by up to c.£1.7m if the system is able to rationalise ‘stranded’ costs.

Workforce:
Whilst overall the proposals would result in a small (c.8%) reduction in overall health staff WTEs, there would be a significant change in the skill mix required (fewer nurses but more therapists).

There would also be a significant increase in the numbers of additional social workers and care workers to support more people being cared for at home.

Access:
Analysis of travel distance for people treated in inpatient care demonstrates that due to having 2 specialist rehab units, for some people, this will mean they are cared for a further distance from home.

Overall however, because more people will be cared for at home or in intermediate care beds within their own communities, the total travel will be significantly reduced (c. 60%).

Implementation:
The proposal would see a reduction in the number of community hospital beds from 100 in 2014/15 to 32 by 2017/18. During this time, alternative care will be developed through: (i) Local intermediate care beds which will increase from 25 to 44 beds; (ii) Integrated Care Service further developed to support an additional c.1,200 people per annum.

Moving from ward based care to significantly more care being delivered at home or within local community intermediate care beds presents significant workforce development challenges. One of the key aims will be to redeploy existing staff wherever possible.

Transitional costs including training and any redundancy costs are still to be defined.

**Overall, the proposed changes would see more elderly people being cared for at home, thus reducing the demand for community hospital beds to 32.**

This would be beneficial to patients due to a reduced likelihood of decompensation in a hospital bed; improving the quality of care provided.

It would also deliver a ‘direct’ annual cost avoidance benefit of £4.6m, with the potential for up to £1.7m more through rationalising stranded costs.
Executive Summary – Urgent access to care

Urgent access to care
National consultation with patients and the public identified that people do not distinguish between urgent and emergency healthcare needs. Urgent and emergency care needs are those that the patient perceives require a response on the same day that they arise. The patient, not the clinician, judges the urgency of the need prior to any clinical assessment and should not be expected to choose correctly between emergency (time-critical) and urgent (not time-critical) care.

Case for change:
Services have developed in an organic and ad-hoc way resulting in un co-ordinated points of delivery, inequitable access, limited integration with primary care and confusion for patients due to inconsistent service provision
- Locally patients report difficulties accessing General Practice and the desire for a more simple and consistent urgent care system, nationally the Keogh review supports this.
- 40% of those attending the Emergency Department (ED) at Chesterfield Royal Hospital could be seen in primary care, sustained delivery of the ED wait target is a challenge and a significant number of admissions could be avoided if alternative services existed.
- The local Minor Injury Units are underutilised, the majority of patients seen have primary care needs, and they contribute to inequitable access across North Derbyshire.

Where thinking has got to....
Emergency Centre at Chesterfield Royal
- Analysis suggests that although the introduction of a co-located urgent care centre at CRH will bring some benefits to the way patients are managed and the care provided, the cost-benefit of implementing this change alone is not sufficient and an alternative approach is required.
- The system needs to do more work to understand how the ED at CRH can be fully integrated with the wider emergency services that sit behind it to deliver better patient care and ensure a financially viable future for the service in the long term. This needs to be done in the context of a whole system urgent and emergency care strategy.

Minor Injury Units (MIUs)
- Offering services dedicated to only servicing minor injuries would be an expensive and inefficient use of resources.
- In addition to ED / UCC provision at CRH servicing Chesterfield and surrounding areas, there is a need to also provide access for minor injury services in the west of North Derbyshire (Buxton).
- Because existing MIUs (and ED/UCC) also provide additional walk-in access to primary care, communities not locally serviced by such receive an inequitable service.
- It is clear that a more integrated urgent care offer built around primary care is required to make more efficient use of resources; this needs to consider how it better services minor injuries. This requires much greater engagement and joint working with Primary Care to develop.

General Medical Practice
- Longer term, greater integration between local GP Practices and between primary care and other providers of urgent care, not just in the period 18:30 to 20:00 but throughout the day, is believed to be the right direction of travel – however this is going to take time.
- CCGs need to lead work with networks of GP practices, organised within local communities, to develop plans to extend access in a way that is sustainable, brings health benefit, and is in line with national planning guidance (December 2015) to deliver by 2020. This needs to be locally developed but provide a consistent and equitable service. It could include the use of ANPs and a wider multi-disciplinary team.

Next steps
- CCGs lead work with GP practices to develop plans to extend access
- System Resilience Group (SRG) oversees the development of clear plans for ED, MIUs and primary care reporting to the C21 programme
- Begin a public conversation (rather than formal consultation) on the future direction for urgent care services in Derbyshire
Executive Summary – Services for people with Learning Disabilities

Services for people with learning disabilities

Every person with a learning disability in Derbyshire is entitled to the same opportunity to lead their life, as valued and respected members of their community, in the same way as everyone else.

Specialist health and social care services need to be organised to provide integrated personalised and self-directed care and support. This care and support must enable everyone to secure their rights, independence, choice and inclusion. Specialist services must give particular priority to those people most at risk of receiving their care and support in high cost institutional care.

Case for Change:

Currently services are not consistently meeting these aims; they are fragmented, inequitable, overly reliant on bed based care and offer poor value for money.

National policy is directing the necessary changes to better meet the aims; most recently, ‘Building the right support: a national implementation plan to develop community services and close inpatient facilities’ (October 2015) set out that:

i) Local councils and NHS bodies will join together to deliver better and more coordinated services.

ii) Budgets will be shared between the NHS and local councils to ensure the right care is provided in the right place.

iii) National guidelines will set out what support people and families can expect, wherever they live.

In Derbyshire, there is particular focus on how we can improve the way we provide care and support for those people with complex needs and multiple disabilities, whilst continuing to reduce the number of people with a learning disability who need to rely on specialist health and social care services to maintain their health and wellbeing.

Proposed future models:

i) Short break (respite) provision:

Whilst there will be a continued offer of short break (respite) options that achieve personalised outcomes, there will be a move from an NHS bed based approach to a range of alternatives that include building based accommodation.

It is expected that these changes will offer significantly better value for money (savings), which will enable re-investment into the development of the robust community services.

ii) Unified Community Learning Disability model:

The core change is to develop a unified, robust community service incorporating the current community learning disability teams, acute and primary liaison services, access to specialist accommodation for assessment and treatment as well as facilities to provide temporary alternative care when needed, with an enhanced Intensive Support Team. Moreover, these services will be integrated (Joined Up) with the broader community based services and adult social care.

Impact and implications:

Costs:

The reduction in acute assessment and treatment beds will enable transfer of resources to support the development of the unified community service.

In addition, offering a fair and equitable alternative personal offer to people using short breaks (respite) would free up resources locked into buildings and inflexible care models. Reinvestment of these resources will further support the 7 day unified community service.

Workforce:

Redirection of resources and priorities will be required to enable the current workforce to change and in some instances increase to address the most complex needs of people with a learning disability.

We will train and support existing staff teams to deliver new care and support pathways.

Implementation:

Subject to the outcome of the Consultation, the proposed implementation plan consists of an 18 month programme; currently planned to commence 1st June 2016 through to 1st March 2018.

The delivery will be influenced by the requirement for robust implementation plans to respond to the National Policy ‘Building the Right Support’ by April 2016.

Overall, the proposed changes would see people with a learning disability and their carers better supported through more integrated care to lead their lives as valued and respected members of the community.
Executive Summary – Other services and site rationalisation implications

Other services and site rationalisation implications

The proposals related to other elements of the business case have a significant impact on the configuration of services within each of the communities.

This presents the need and opportunity to further consider how other community services, currently delivered from the sites affected, can be delivered most effectively in the future.

Consequently, site rationalisation opportunities have been considered taking account of the impact of the proposed changes, services currently delivered from the sites impacted, the state of the site and its potential role within the development of community hubs.

Proposed changes:

Taking account of the proposed changes to Specialist OPMH, Dementia day units and community bedded care, seven community hospital sites would be impacted.

Of the seven sites:

- Sites at Cavendish and Walton would continue to deliver ward based bedded care. As such the hospital facilities are still required and therefore there has been no further consideration of these sites.
- No proposals are yet being made to change the provision of urgent care services including MIU facilities, which require access to hospital facilities (e.g. diagnostics). As such, the hospital facilities are still required and therefore there has been no further consideration of these sites (at this stage).

Other sites at Bolsover, Clay Cross and Newholme would no longer provide bedded care; so as a result of further more detailed consideration:

- The Bolsover site would be used for only a small number of attendances (c.2,300) and have very low utilisation (8% of clinical space). It would therefore be very costly to deliver the residual levels of care (£325 per attendance excluding cost of care).
- The Clay Cross site would be used for a high number of attendances (c.22,600) and have a higher utilisation (27% of clinical space). The site is also extensively used as a base for other local clinical service teams. It would provide a cost effective site (£18 per attendance excluding cost of care).
- The Newholme site would be used for a significant number of attendances (c.12,500) but have a low utilisation (18% of clinical space). The site is used to provide corporate office space which could be relocated elsewhere with no impact on patients. It would be a costly site to run (£49 per attendance excluding cost of care).
- Consequently the proposal is to close Bolsover and Newholme sites.

Impact and implications:

Costs:

- The proposed changes would deliver a net cost saving per annum of c.£0.9m.
- So instead of spending this money on costly and outdated buildings, it will instead be invested in care provision i.e. getting better value for money.

Workforce:

- The workforce implications of other proposals forming part of this PCBC are described elsewhere in this PCBC.
- In addition, staff currently providing patient services (outpatients / clinics) may also be impacted – needing to deliver care from alternative local sites. This will be considered further following consultation.
- And, staff currently providing ‘site services’ (estates, ancillary, etc.) would also be affected.

Workforce development principles will apply to all staff impacted by the proposed changes; the intention will be that ‘staff will be retained, retrained and redeployed wherever possible’.

Quality and Access:

- Current outpatient / clinic based services or appropriate alternatives will continue to be delivered within local communities.
- Alternatives sites would be selected which are accessible and to help join up care services – in keeping with the aim to develop community hubs and networks.

Overall what is proposed:

i. To close sites at Bolsover and Newholme to save c.£0.9m p.a. (net of site re-provision costs) which can be reinvested in care provision i.e. get better value for money.

ii. A commitment to continue to deliver services locally within each community.

iii. To continue to review other sites as other services proposals are developed.

These proposals are subject to:

- Support from Commissioners;
- Review and approval by Provider Boards who own the assets.
Executive Summary –
(i) Processes used to develop the proposals
(ii) Understanding what it would take to deliver the proposed changes

Processes used to develop the proposals
Proposals have been co-developed through extensive and structured processes of engagement, analysis and review:

Engaging stakeholders in the development of the proposals
The North Derbyshire 21st Century Joined Up Care programme has undertaken substantial engagement with a wide range of stakeholders and public since it commenced pre consultation in 2012. This ongoing dialogue has informed the development of the programme as a whole and underpinned co-creation of the proposed changes.

2012-13 was spent talking with and listening to stakeholders and the public in order to establish, develop and shape the vision, case for change and emerging ideas for joined up health and care services.

To ensure the proposed models and options for delivery were understood and owned by the public, clinicians and professionals, more recent engagement activity has focused on the co-creation of alternative care models.

How preferred options were identified
A structured process enabled the Community Hub Groups to move through the development and ‘funnelling’ of an initial broad range of potential options for the future provision of OPMH and Community Bedded care down to a small number of options which were analysed and considered in appropriate detail.

The process was directed by a set of agreed principles and objectively evaluated on the basis of a set of agreed criteria.

Models of care were defined and agreed prior to determining how and where care should be delivered.

NHS-E assurance (‘the 4 tests’)
The ‘Planning, assuring and delivering service change for patients’ guidance (NHS England; Nov. 2015), reiterated the four tests for service change as part of the Government Mandate to the NHS. The service change proposals for Community Hubs as set out in this PCBC have been assessed against the four tests to ensure the CCGs are meeting the requirements.

Equality assurance
The 21C Programme has made a proactive commitment to considering the impact of any changes on the equality groups. Groups have been engaged and this will continue on an ongoing basis.

Understanding what it would take to deliver the proposed changes

Risk assessment (including quality impact)
Across the 21C Programme a consistent approach to measuring, managing and reporting risks is applied. In addition, the Community Hubs Working Group and CPRG (through means of a Quality Impact Assessment) has given initial consideration to the implementation risks associated with the proposals.

Workforce planning and development
Workforce development is the key part of the implementation of the proposed changes. We already have a successful track record of delivering a transition of care from hospital (ward) based settings to community based delivery.

We have defined a set of principles to direct workforce development.

Whilst the overall scale of the changes is significant, we are confident they are achievable over the period of the programme.

Commissioning, contracting and finance
Commissioners and Providers have worked together to understand the overall financial scale of the proposed changes and to agree in principle how they would be able to support the necessary investments and how to share the potential benefits of the proposed changes.

Implementation principles, timeline and ‘what it would take’
The particular proposals contained in this PCBC are subject to public consultation and as such they are still formative and may change. Consequently, specific and detailed implementation planning has not yet been completed.

Nevertheless, the Community Hubs Working Group have defined a set of principles which would direct implementation planning and have begun to consider ‘what it would take’ to deliver the changes.

Consultation messages and consultation planning
Public consultation messages have been developed with the help of lay representatives and clinicians / professionals who have been actively involved in the programme.

These are being developed into the consultation document and other supporting materials.

An outline consultation approach and plan has been developed.
Executive Summary: agreement /support to date and next steps

Boards have already reviewed the PCBC in three stages:

In stage 1 proposals related to community bedded care and specialist OPMH care were approved / agreed by commissioners and the models of care were supported by providers.

In stage 2 the proposals related to support for people with learning disabilities were also agreed and supported by commissioners and providers. Boards understood that it had not been possible to develop firm proposals related to Urgent Access to Care and supported an increased focus on the Urgent Care work, and for the remit and the membership of the workstream group to be broadened to better encompass primary and community care in order that an integrated ‘solution’ could be developed.

In stage 3 the proposed changes on the community hospital sites were understood.

Following the principles of inclusion and transparency all three stages of the PCBC were taken separately to all the Boards and Governing Bodies of all partner organisations and agreement reached. Suggestions made by any of the Boards/Governing Bodies at one stage were considered by the others at the next stage. This cross system approach to the development and agreement of the proposals was facilitated by the senior level 21C Plan Delivery Group. This allowed all Boards and Governing Bodies to sign off the stage 3 PCBC, and all partner organisations to agree the following.

All partner organisations have now agreed the following:

1. **Specialist Older Persons Mental Health (OPMH):** (subject to consultation) Commissioners **approved**/ Providers **supported** the proposed changes to OPMH bedded care
2. **Community Bedded Care:** (subject to consultation) Commissioners **approved**/ Providers **supported** the proposed changes to community bedded care
3. **Dementia Day Unit services :** (subject to consultation) Commissioners **approved** / Providers **supported** the proposed changes to Dementia Day Unit services
4. **Urgent access to care:**
   i. **Agreed** the recommendation that CCGs lead further work overseen by the System Resilience Group (SRG) reporting to the C21 programme
   ii. **Agreed** to exclude urgent care from public consultation, but to develop further plans, and thereafter undertake public consultation
5. **Learning Disabilities**
   1. **Agreed** in principle to the proposals
   2. **Agreed** to exclude Learning Disability from public consultation, but to develop further plans, and thereafter undertake public consultation

6. **Other services and site rationalisation implications:**
   i. (Subject to consultation) Commissioners **supported** / DCHS **approved** closure of hospital sites at Bolsover and Newholme with continued delivery of services locally within each community
   ii. Commissioners **agreed** the continued review of other sites as other service proposals are developed
7. **Workforce planning and development – noted** the principles; scale and nature of the workforce changes; explanation of why this is achievable
8. **Commissioning, contracting and finance –**
   i. **Noted** the overall combined financial scale of the proposed changes
   ii. **Approved** the proposed cross system commissioning principles
   iii. **Agreed** the cross system funding arrangements that would be necessary to implement the proposals
9. **Implementation – noted** the principles, timeline and ‘what it would take’
10. **Consultation document and plans – noted** the development of the key messages and the outline consultation plan

And, what’s next?

**March:** Development of the consultation document and consultation plans
Update PCBC as may be necessary following Board review
Ongoing pre-consultation engagement
Preparation for the NHS-E Gateway Review

**April:**
NHS-E Gateway Review
Update the PCBC and consultation materials
Boards final review PCBC and consultation materials

**May:**
Public consultation launched – subject to Board and NHS-E approvals

**September:**
Governing Bodies and Boards separately consider a summary of the consultation responses, together with the amended business case for approval.
In the case of the two CCG Governing Bodies reaching different decisions representatives from each of the CCG Governing Bodies will hold a joint committee to reach a single joint decision by which both CCGs will abide.
Foreword by Clinical Commissioning Groups

The NHS was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth.

Three core guiding principles underpinned this ideal:

- That it met the needs of everyone
- That it would be free at the point of delivery
- That it would be based on clinical need, not ability to pay

These three tenets have guided the development of the NHS since its inception in 1948 and, in time, additional principles were included to embed the system into communities. These included:

- Provide a comprehensive range of services
- Shape its services around the needs and preferences of individual patients, their families and their carers
- Respond to the different needs of different populations
- Work continuously to improve the quality of services and to minimise errors
- Support and value its staff
- Use public funds for healthcare devoted solely to NHS patients
- Work with others to ensure a seamless service for patients
- Help to keep people healthy and work to reduce health inequalities
- Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance

Here in North Derbyshire, the system of healthcare has evolved over time as a collaborative close working partnership between healthcare providers and social services with the aim of providing the highest possible standards of care within the confines of the budgets we work under.

Over the last few years, our partnership has become aware that the increasing demands on the system in terms of patient need, a significant increase in an elderly population and huge pressures on all parts of the health and social care system have required a fundamental rethink on what we are trying to provide for patients and the gaps in service provision opening up and wide variation in equity of access to care.

Across the two clinical commissioning groups and the network of health and social care providers which constitute the North Derbyshire unit of planning and through the structures of the joint 21st Century Board, we have undertaken a review of the future of what the healthcare system in North Derbyshire could look like and how it can deliver higher quality of care, across all age groups, in an equitable way, and building on the success of previous initiatives, but also learning from and understanding past mistakes and gaps in the provision of services.

The aim is fundamentally to deliver high quality care closer to home, integrating health and social services through a team approach delivered through hubs in the community. This demands close cooperation and working between all providers including GPs, hospital and community services, ambulance and mental health and social services to deliver better care in a coordinated, non duplicated fashion to patients and fundamentally shifting the emphasis from traditional patterns of bedded care to greater emphasis of supporting patients at home. The provision of bedded care needs to be targeted at those in appropriate need.

This is not a new concept and indeed has been utilised in other areas and has been an evolution of changing needs within the community.

The review to date has been an enormous undertaking with special emphasis on what is required for true and robust integrated care in the community and a realistic appraisal of what is actually required in terms of hospital beds in both acute and community settings and the requirements of improving access to care through urgent services.

It is important to understand that this is not about "cuts" in services, it is about utilising the limited resources we possess to deliver better care to all, shifting the emphasis to care in the community. Redirecting monies, assets and personnel, where necessary to achieve this equitably across the whole of North Derbyshire. There is a finite resource and we do face considerable financial challenges, as we do indeed in finding sufficient clinical and non clinical capacity, but the aim is deliver better quality care and surely this is the correct approach and aligns with the founding principles of the NHS described above.

Some changes will be required, some may seem onerous, but all partners are of one mind, simply doing nothing is not an option. We intend to consult with the public on our deliberations in an open minded and constructive fashion to ensure that proposals are only agreed after taking their views and feedback into account.
The Clinical and Professional Reference Group comprises senior clinicians and professionals drawn from Hardwick and North Derbyshire Clinical Commissioning Groups, Derbyshire County Council and from the provider organisations in the north of the county. The group is chaired by the Clinical Chair of North Derbyshire CCG and the Clinical Chair of Hardwick CCG attends along with other senior General Practitioners. Directors of Nursing and Medical Directors attend from Chesterfield Royal Hospital NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Derbyshire Health United and Ashgate Hospice, as well as the Chief Nurses from both Clinical Commissioning Groups.

As a group of senior clinicians and professionals we have led the development of the clinical model for the community hubs business case. We therefore fully support and endorse the clinical models that underpin this case, and the business case itself. We believe that implementation of the case will improve the quality of services provided to patients, and have undertaken a quality impact assessment of the business case and the direction of travel which supports that view.

The Clinical and Professional Reference Group is therefore pleased to offer its full support to this business case.

Chair North Derbyshire Clinical & Professional Reference Group
Purpose of the document and context

This section describes the:

• Purpose and structure of the document
• Context within which the Pre Consultation Business Case has been produced
• Process of engagement through which the proposals have developed
Purpose, structure and contents of the document

Purpose
The Pre-Consultation Business Case (PCBC) sets out the context, case for change and proposed future models of care that contribute to the development of ‘Community Hubs’ – through which joined up community based services will be delivered across North Derbyshire.

The PCBC is being reviewed by Commissioner and Provider Boards to provide approval or support ahead of a planned Public Consultation.

It should be noted that approval of the proposals will still be subject to:

i) Public Consultation
ii) Contracting agreements
iii) Any specific business case requirements (e.g. capital builds / investments)

Structure of this document
The document provides:

• The strategic context in relation to community hubs and fit with the wider system plan
• For OPMH dementia care (specialist beds and day unit services) and community bedded care:
  • A description of the scope of the proposed changes
  • The case for change
  • How the proposed changes were developed
  • A description of the proposed changes
  • An overview of implications
  • An outline implementation plan
  • A summary of the benefits and implications
• Summary proposals for changes to care for people with learning disabilities
• Summary of the status and plans for the development of urgent care services
• Summary of the impact of the proposed changes on the sites from which they are delivered and proposals for consequent site rationalisation
• Overview of:
  • How we have engaged with stakeholders (incl. the public)
  • The processes used to develop the proposals (incl. option evaluation)
  • Commissioning, contracting and financial arrangements
  • Potential implementation timeline and considerations
  • Workforce planning and development
  • Risks and mitigations
  • An overview of the consultation messages and consultation plan
• Conclusions and next steps
• Appendices providing more detailed analysis and explanation
Strategic context – Joint Strategic Needs Assessment and Health and Wellbeing priorities

The Joint Strategic Needs Assessment and the consequent Derbyshire Health and Wellbeing Strategy inform the priorities which are being addressed by the North Derbyshire System Plan including the Community Hubs PCBC.

Joint Strategic Needs Assessment (JSNA)

The JSNA identifies a number of factors which have provided the context and directed the priorities which are being addressed by this PCBC. These are summarised at appendix and described in detail within the JSNA.

Key factors directing the PCBC:

Ageing population:

North Derbyshire has an older population compared to England. By 2037, the population of Hardwick and North Derbyshire CCGs is projected to increase by 9% and 8% respectively, with an estimated 29% of Hardwick CCG and 31% of North Derbyshire CCG’s population being aged over 65 years.

The increase in population size will place greater demand on health and social care services, with an aging population having greater needs. The frequency of most long term conditions, including dementia, increases with age. Older adults are also more likely to have multiple health problems, be frail and be less independent. An increase in number of older adults will also increase the number of individuals with caring responsibilities, especially if people are supported to live independently where possible. The health and social care system across North Derbyshire must therefore adapt to meet these pressures.

Wider determinants of health:

Levels of socio-economic deprivation vary across North Derbyshire. The highest rates of socio-economic deprivation are found in Chesterfield and Bolsover, where approximately one in four of the population live in the most deprived neighbourhoods in England. In general, levels of deprivation are lower within other districts, but there are communities in Buxton, Matlock and North East Derbyshire that also fall into the 20% most deprived areas nationally.

Prevalence of long term conditions:

People with one or more long term conditions are responsible for approximately 50% of GP appointments and 70% of days spent in hospital. The prevalence of most chronic health conditions increases with age, and is also higher in areas that experience more socio-economic deprivation. Supporting individuals through primary care and community-based services to help them manage their condition and remain as well and independent as possible will reduce the need for more costly hospitalisations.

Derbyshire Health and Wellbeing Strategy

There is a drive both nationally and locally to change the emphasis of the health system from one which treats ill-health to one which prevents people becoming ill in the first place. This is reflected in the Health and Wellbeing Strategy for Derbyshire 2015-17. As the basis of the strategy, which was refreshed in the autumn of 2015, the Health and Wellbeing Board have identified 4 priorities where it will focus activity:

- Keep people healthy and independent in their own home
- To address the links between socio-economic disadvantage and health inequalities through building social capital
- Taking a place-based approach to create healthy communities
- Support the emotional health and wellbeing of children and young people

The strategy does not provide a comprehensive long list of the work that the Board collectively, or as individual partner organisations, are undertaking and consider ‘business as usual’. It is intended that the Health and Wellbeing Board will focus activity on the delivery of these four priorities over the next two years.

Successful implementation of the Health and Wellbeing Strategy’s priorities will require health and social care partners to work collaboratively to maximise the impact on preventing avoidable ill health and reducing health inequalities.

Summary

The proposals within this PCBC for developing Community Hubs provide opportunities to improve the health of the population of North Derbyshire and reduce health inequalities; through provision of joined-up community-based services that are able to respond to the health needs of the different communities.

Developing a preventative approach will enable individuals to maintain healthy lifestyles, and provide support for individuals with long-term conditions to manage their condition and live independently.

Targeted approaches that reach individuals and communities most at risk from poor health outcomes would help to reduce health inequalities currently seen within North Derbyshire.
**Strategic context**

Community Hubs are a critical element of the whole system plan to improve how care is provided for the people of North Derbyshire. Community hubs will provide and support joined up community based care services.

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**The North Derbyshire Five Year System Plan**

In 2011 a group of stakeholders came together to set out the start of a vision for the future of services in North Derbyshire. This took shape through quarterly public and patient involvement events and further discussions with clinical and professional colleagues to ensure full support for the plans and direction of travel. Stakeholders recognised that current system behaviours which are typically reactive and are characterised by organisation and role boundaries, must be replaced by a system that is centred on people and communities.

The message loud and clear from the public was that despite services in the main being of good quality, services were too often fragmented, difficult to navigate and consequently, people fell through the gaps.

It was clear that this needed whole system transformation rather than picking away at individual parts of the system, and in light of this Health and Care Commissioners and Providers in North Derbyshire worked together to develop a 5 Year ‘System Plan’ for the future of care.

- The plan summarised the need for change:
  - ‘Fundamentally, we need to better meet the changing needs of our people – where increasingly the ageing populations’ needs are ongoing and complex (social, physical and mental). Some of the existing services are not resilient due to skills shortages and configuration. And, if services are not changed, the system will have a c.£150m funding gap in 5 years’ time.’

- And it describes major changes to the way in which care will be provided, in particular, the development of Integrated Care (‘JoinedUpCare’) to better meet the ongoing care needs of the people of North Derbyshire.

- The plan described a new system that will:
  - Require individuals and teams to work in a more integrated way - organised around the person and community.
  - Recognise the key role that carers and voluntary services provide.
  - Provide ‘community hubs’ from which local health and care services operate.
  - Integrate services into wider networks which offer effective access to specialist expertise and services.

**Fundamentally, we want the system to keep people:**

- **Safe & healthy** – free from crisis and exacerbation.

- **At home** – out of social and health care beds.
- **Independent** – managing with minimum support.

... which will be founded on building strong, vibrant communities.

**Five Year Forward View and Sustainability and Transformation Plans**

The NHS has published its strategy – the ‘Five Year Forward View’ (SYFV). The aims and emphasis of this strategy is entirely consistent with the North Derbyshire Five Year Plan.

On a Derbyshire-wide basis, to deliver the SYFV, health and care organisations are now working together to develop their Sustainability and Transformation Plans (STPs) which will be place-based, multi-year plans built around the needs of local populations. Again, will be consistent with and built upon the existing plans including those for community hubs.

**The Role of Community Hubs in the System Plan**

Community hubs will provide and support joined up community based care services; developed with local people to meet their needs.

**Hubs will:**

- Provide ‘out of hospital’ places from which JoinedUpCare will be delivered.
- Service the needs of children and adults.
- Support the integration and delivery of mental health, physical health and social care – to meet whole needs of people (‘whole person care’).
- Offer urgent, planned and bedded care to complement services provided at home and in hospitals - delivering the right care, in the right setting, by the right people.
- Meet the specific needs of local communities; not one size will fit all.
- Recognise that different communities will start with different services and facilities (including primary care).
- Be delivered from a combination of the most appropriate physical locations to balance access and resilience needs.
- Take account of housing developments and new facilities.
- Consider how technology can support new approaches to care delivery.

The plan anticipates increasing funding in community based services but also significantly changing how this is used (less bedded care and more joined up services).

‘Community hubs’ is also the name of the work stream which is co-ordinating the development of the hubs. The work stream is one of nine which have been prioritised to deliver the ambitions set out in the plan.
Community Hubs / Networks

The vision for community Hubs has been developed and refined over a 6 month period with both the public and professionals in the health and care system to build a shared understanding and goal.

The Vision for Community Hubs

Integrated (Joined Up) Care is seen as being at the heart of the Community Hubs vision; building on what is good already.

Hubs will provide a focal point from which community based services are provided and from which care is coordinated for people and professionals.

Hubs will support and supplement the ‘personal care networks’ (person, carers, family, primary care, ...) which people rely to keep themselves ‘safe & healthy, independent and at home’.

Hubs will include the full spectrum of health, social care and well-being (physical, mental, social and voluntary services); the concept of whole system, whole person (multi-disciplinary / multi-agency) at all levels.

Hubs will have a ‘community role’ to reinforce and contribute to the development of community resilience. The hubs will not only support ‘ill-health’ but play an active part in the wellness of the local community (preventative approach); creating a sense of responsibility and ownership for taking care of ourselves and each other.

Hubs will be based on strong relationships; between the people using in the hubs and the professionals they interact with; between all the professionals working there (regardless of organisation) and amongst the people themselves by creating the sense of ‘community’.

Hubs will have a vital coordination role to ensure appropriate and effective sharing of information between professionals and for citizens.

Hubs will be flexible and adaptable to changing needs and requirements of the community it serves; they will also be organic in the way they evolve. “Hubs must be flexible in what they set out to do now and in the way they sense and respond to changing needs in the future. What they must have is the mechanism to make that flexibility and responsiveness a reality”.

In the concept of a hub, there is no specific distinction between a physical building or having a more virtual ‘network’; there is merit in a combination of both.

There will be a variation in the size and scope of the services available from the physical hubs (e.g. some offering urgent care and/or bedded care facilities); this will be dependent on scale. Ultimately the physical aspects would be connected through the network; with no boundaries.

The hubs will support 7 days a week care, and where necessary availability extended to 8pm/10pm; there is recognition that there is insufficient demand to warrant everything being available into the night. Specialist services would be accessed outside of the hub for specific needs and for short periods of time.
Developing services to meet specific local community needs

North Derbyshire is a diverse geographical area, ranging from very rural areas to the west in the High Peak and Dales areas to an urban centre in Chesterfield in the east. Community Hubs will be developed to meet the specific needs of local communities; in a way that anticipates ongoing changes in needs and expectations.

‘Local Communities’

The 5 Year Plan recognises that the needs and situation of people varies significantly across North Derbyshire and hence – ‘not one size fits all’.

Consequently, local communities have been identified as a means to engage people in the development of services to meet their specific needs.

This includes both the development of:

(i) Cross functional teams (health, social care and voluntary organisations) providing integrated care (JoinedUpCare).

(ii) Community hubs - ‘out of hospital’ places from which care will be delivered (as outlined on the previous page).

Whilst the definition of these ‘local communities’ is not fixed (we will learn and adapt as needs and ways of working are better understood), as a starting point, eight natural communities (covering the whole of North Derbyshire) were defined that largely link back to District and Borough Council boundaries and in turn to the north of the County Council which covers the whole of Derbyshire.

It is acknowledged that the fit is not perfect and that people access services across boundaries; the health and care system will need to work flexibly to ensure this is accommodated.

It should be noted that by considering the needs of the eight local communities, in line with the vision for community hubs this does not imply that there will be one physical ‘community hub’ for each community. There could be multiple places from which services are delivered within a community or places may be shared across more than one community.

<table>
<thead>
<tr>
<th>Local Community</th>
<th>District and Borough Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dronfield, Killamarsh and Eckington</td>
<td>North East Derbyshire</td>
</tr>
<tr>
<td>2. North Bolsover</td>
<td>Bolsover</td>
</tr>
<tr>
<td>3. Chesterfield East</td>
<td>Chesterfield</td>
</tr>
<tr>
<td>4. Chesterfield Central</td>
<td>Chesterfield</td>
</tr>
<tr>
<td>5. South Hardwick</td>
<td>North East Derbyshire</td>
</tr>
<tr>
<td>6. Dales</td>
<td>Derbyshire Dales</td>
</tr>
<tr>
<td>7. Buxton</td>
<td>High Peak</td>
</tr>
<tr>
<td>8. Central High Peak</td>
<td>High Peak</td>
</tr>
</tbody>
</table>
Outline of the process used to develop community hub proposals and consult with the public

The diagram below sets out the high level activities that have been completed to produce the Community Hubs service development proposals and the Pre Consultation Business Case.

Wide spread public, clinical and professional involvement to develop models & options
Key groups and meetings enabling this:
- Public engagement sessions
- Community Hub Working Group and Community Hub groups in each community
- Clinical and Professional Reference Group
- East Midlands Clinical Senate
- Cross System ‘read-across’

Pre Consultation Business Case Stage 1
- OPMH
  - Long list of options
  - Financial / non financial assessment of options
  - Preferred option
- Community beds
  - Long list of options
  - Financial / non financial assessment of options
  - Preferred option

Pre Consultation Business Case Stage 2
- Learning Disabilities
  - Development of local plans in line with national policy to develop community services and close inpatient services
  - Financial / non financial assessment
- Urgent Care
  - Long list of options
  - Financial / non financial assessment of options
  - Options assessed unviable
  - Challenges confirmed, and direction of travel set,
- Other community services

The reason for initially focussing on OPMH, Community Beds, Learning Disabilities and Urgent Care is the overwhelming case for change in these areas. However the proposals related to each of these four areas requires and provides the opportunity to consider how other co-located services delivered from particular sites can be delivered most effectively in the future

Consideration of other services delivered from sites impacted by proposals

Full Pre Consultation Business Case (Stage 3)
- Workforce Development
- Site Rationalis’n

Launch Consultation
- NHSE Review

Strategic Outline Case (SOC)
- SOG to Boards

Early Pre-Consultation
- Oct 14
- Jan 15
- Jul 15
- Jan 16
- Apr 16

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
Service proposals

This section covers the proposals for:
1) Specialist Older Persons Mental Health (OPMH)
2) OPMH Dementia Day Unit Services
3) Community bedded care
4) Urgent Access to Care
5) Learning Disabilities
6) Other community services impacted by the proposals and consequent site rationalisation proposals
Scope of Community Hubs / Networks development proposals
The diagram below highlights the services that have been the initial focus for developing community hubs and are therefore within the scope of the Pre Consultation Business Case.

Community Hubs / Networks

Providing community based services including...

- Personal Care Network (@ home)
- Co-ordinating services & teams

Services:

- Older Persons Mental Health
  - Specialist Older Persons Mental Health beds
  - Out of area placements
  - Community Mental Health Team
  - Dementia Day Units
- Community Beds
  - Community based intermediate care beds
  - Acute hospital beds
  - Residential care beds
  - Nursing home beds
- Urgent Access to Care
  - ED
  - GP streaming
  - Out of Hours face to face
  - MIUs
  - Walk-in Centre
  - Primary Care
- Learning Disability
  - Short breaks (respite)
  - Unified Community LD service
- Other Services (Impacted by changes)
  - Nursing & therapy clinics
  - Specialist acute OP
  - Diagnostics
  - Primary Care
  - Children’s Services

PCBC Stage:

- Pre Consultation Business Case Stage 1
- Pre Consultation Business Case Stage 2

Implications:

(Full PCBC Stage 3)

Workforce Development
Site Rationalisation

Key:

✓ Considered
✗ Not covered

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL

23
Specialist Older Persons Mental Health (OPMH) beds

The sub-section contains:
- Service scope covered by the proposals
- Summary of the case for change
- Description of the evaluation process
- Proposed service changes
- Travel access analysis
- Current and proposed service costs
- Financial benefits
- Outline of the workforce changes
- Outline of how the implementation may be phased
- Summary of the benefits and implications
OPMH - scope

Older peoples mental health services in broad terms are required to meet two distinct needs (i) those related to disease of the brain, primarily (but not exclusively) dementia and (ii) those related to how the brain functions, for example depression, anxiety, psychosis. The focus of proposed service changes described in the remainder of this section are on those services that support people who are severely affected by dementia.

Living Well with Dementia

It’s estimated that there are currently c.6,000 people with dementia living in North Derbyshire. The incidence of dementia is positively correlated with age i.e. as age increases the percentage of people affected by dementia increases. Between the ages of 65 and 69 only 1.3% of people are affected, but between 85 and 89 the proportion in creases to 20%. The number of people living with dementia in North Derbyshire is therefore forecast to rise significantly over the next 5 years given an expected 15% increase in the people aged over 65 and a 25% increase in the people aged 85 and over. This is estimated to be equivalent to an additional 1,000 people living with dementia.

Dementia presents a significant challenge to the local health and social care system given people affected by dementia and their families and carers often face difficulties in trying to live well with dementia. To deal with this challenge Derbyshire County Council and the local NHS Clinical Commissioning Groups have agreed a Derbyshire Joint Dementia Strategy: Living Well with Dementia (2014) that sets out evidenced based actions to reduce the incidence of dementia by supporting possible lifestyle changes alongside new and revised models of care. The range of conditions that Dementia is used as an umbrella term for and the extent of the severity of the condition for the 6,000 people in North Derbyshire is described below.

<table>
<thead>
<tr>
<th>Severity</th>
<th>Estimated Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>900 (15%)</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>1,800 (30%)</td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>3,300 (55%)</td>
<td></td>
</tr>
</tbody>
</table>

Range of conditions covered by ‘Dementia’

- Alzheimer’s disease (most common)
- Vascular dementia
- Lower incidence dementias
- Mild cognitive impairment

Scope of proposed services changes

The scope of the proposed service changes described in this section relate to those people with moderate to severe dementia, which in Derbyshire Dementia Pathway terms are those most commonly in Phases 4 and 5.

For these people, when (i) an acute/crisis episode is experienced; and/or (ii) a complex care package breaks down through lack of specialist professional treatment and intervention; and/or (iii) challenging behaviours or psychological symptoms that make it difficult for a carer to cope in the home environment – they are currently admitted to a specialist OPMH unit.

These specialist OPMH units are currently provided across three facilities: (i) Walton Community Hospital (2 wards) in Chesterfield (ii) Newholme Community Hospital in Bakewell (iii) Cavendish Community Hospital in Buxton.

In total these units currently care for 243 patients a year across a total of 50 beds. The total operating cost for these services is £8.7m, which is equivalent to £36k per patient admitted.
OPMH – why change

For those people who have developed behavioural or psychological symptoms in dementia (BPSD) the current response is to admit them to one of three specialist OMPH inpatient units in North Derbyshire. Evidence suggests that this model of care can be traumatic for people as well as being clinically and financially unsustainable with the forecast growth in demand

Improving the quality of care:

• Evidence suggests that hospitalisation of people with dementia has negative impacts on both physical and mental health (King’s Fund 2008: Paying the Price) and leads to:
  • Increased risks of falls and urinary tract infections
  • Greater cognitive impairment as a result of taking people out of their usual place of residence and local community
  • Decompensation due to care received reducing levels of activity
  • Increased risk of depression due to isolation
  • A return to home becoming impossible for some

• The Alzheimer’s society reported that 83% of people with dementia want to stay in their own homes.

• Integrated pathways do not currently exist between the inpatient specialist OMPH beds and the community mental health teams.

• Nursing and residential homes are high referrers to dementia inpatient beds.

Improving the sustainability of the workforce:

• With the existing care provision arrangements the forecast increase in numbers of older people with associated dementia needs, including those with severe dementia will result in an increase in the numbers of people being cared for in the 3 inpatient units i.e. being taken out of the place they call home.

• Current workforce (nursing in particular) configuration is insufficient to meet increasing OMPH inpatient activity and acuity across the 3 units. Therefore may fail to meet safe staffing guidance in the future and attain compliance with national benchmarks.

• Difficult to maintain workforce resilience - known recruitment pressures of Band 5 RMNs and challenging to deliver consultant psychiatric cover across 3 sites.

Improving service effectiveness and efficiency:

• Health spend across all North Derbyshire OMPH services is currently £3.3 to £1 inpatient : community. North Derbyshire remains behind the national trend for moving to community based interventions. Both commissioners and providers believe this is a key driver to the system failing to consistently meet the Quality Outcomes for People with Dementia 2010 published by the Government.

• In 2011 the All-Party Parliamentary Group on Dementia challenged the NHS to reduce hospital beds and free up £1bn for community based dementia services. It called for services such as outreach teams and better support at home to reduce the number of people needing hospitals care and reduce the length of stay to hospitals.

#JoinedUpCare - keeping people
✓ Safe and healthy
✓ At Home
✓ Independent

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
**OPMH – option evaluation**

The proposed service changes for older peoples mental health services are the result of an evaluation process that was designed to enable the Community Hubs workstream to consider, in a structured way, alternative models of care to those that currently exist, the options for delivering these and the preferred way forward for the system.

1. People kept at home and independent wherever possible
2. Improved access to care
3. Improved service effectiveness and efficiency

See Appendix for Full Criteria
**OPMH – service description of proposed new delivery model**

The proposed service change would see half of those people who develop behavioural or psychological symptoms in dementia (BPSD) being treated at home by a specialist community based team, known as a Dementia Rapid Response Team, rather than in an inpatient hospital setting. Specialist OPMH beds would still be provided for those with the most severe symptoms, however these would be fewer in number and consolidated on one site.

Needs of people with moderate to severe dementia are managed by the Community Mental Health Team, the aim being to respond to changing needs to deliver support and treatment to enable well-being and support living at home. These services operate 9-5, Monday to Friday and referrals are responded to within two working days or up to four weeks depending on urgency.

---

<table>
<thead>
<tr>
<th>As is:</th>
<th>Proposed new delivery model:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When the needs of these people demand a crisis response</strong></td>
<td><strong>When the needs of these people demand a crisis response</strong></td>
</tr>
<tr>
<td>A service that is solely reliant on admission to a bed to manage people with moderate to severe dementia when their needs demand an urgent or crisis response</td>
<td>A service that can deliver rapid response with expert assessment and intensive home support for a short period of time, supported by highly specialist OPMH beds when the level of need is such that admission can’t be avoided</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>OPMH bedded care</th>
<th>Dementia Rapid Response</th>
<th>Specialist OPMH beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 sites - Walton (purpose built and used to care for those patients with the most severe systems across North Derbyshire), Cavendish &amp; Newholme</td>
<td>Equivalent of 30 beds</td>
<td>1 site – Walton</td>
</tr>
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**OPMH – service description of proposed new delivery model**

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<td>Equivalent of 30 beds</td>
<td>1 site – Walton</td>
</tr>
</tbody>
</table>
OPMH – service description of proposed new delivery model

Under the proposed service change each of the eight communities across North Derbyshire would have access to a Dementia Rapid Response Team usually through the Community Mental Health Team. When the level of need is of such a severity that admission cannot be avoided, inpatient care will be provided from one ‘Centre of Excellence’ serving the whole of North Derbyshire.

Community Dementia Rapid Response Team
- Support will be provided to all eight communities across North Derbyshire, with access through the Community Mental Health Team.
- Community based service that can deliver a rapid response with expert and intensive at home support for a short period of time, thus providing a real alternative to hospital admissions, as well as supporting faster discharges (reducing length of stay) from specialist OPMH beds.
- The Team will offer rapid (within 6 hours) assessment, care and treatment in a person’s home or the place they call home. Where home treatment is required intervention will be agreed and a plan of care put in place, lasting up to eight weeks.
- The Dementia Rapid Response Team will be available 365 days per year between the hours of 08:00 and 20:00
- The service will provide multi-disciplinary assessment and treatment and work in an integrated manner with local services carried out in a persons own home.
- In addition the Team will support swift discharge home from A&Es, Medical Assessment Units and Acute inpatient beds by linking with Mental Health Liaison Teams (a detailed description of the DRRTs role is provided in the appendix).

Walton – Specialist Inpatient OPMH Centre of Excellence
- 30 specialist inpatient OPMH beds to care for those patients with the most severe behavioural and psychological symptoms in dementia.
- Beds will operate 24/7/365 to deliver specialised multi-disciplinary assessment and treatment and to arrange a suitable post-hospital care package.
OPMH – Travel access for OPMH bedded care

Analysis of travel distance for people treated in inpatient care demonstrates that due to having a single specialist centre, for some people, this will mean they are cared for a longer distance from home. Overall however, because more people will be cared for at home, the total travel will be significantly reduced (c. 30%).

Current model (with forecast 20% growth):

<table>
<thead>
<tr>
<th>Community</th>
<th># pts</th>
<th>Beds</th>
<th>Avg dist (miles)</th>
<th>Total dist (miles)</th>
<th>Avg time (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: DRONFIELD AND NORTH EAST</td>
<td>14</td>
<td>3.4</td>
<td>7.6</td>
<td>110</td>
<td>17.5</td>
</tr>
<tr>
<td>C2: NORTH HARDWICK AND NORTH EAST</td>
<td>43</td>
<td>11.3</td>
<td>10.0</td>
<td>432</td>
<td>22.9</td>
</tr>
<tr>
<td>C3: CHESTERFIELD EAST</td>
<td>36</td>
<td>9.1</td>
<td>3.6</td>
<td>128</td>
<td>8.2</td>
</tr>
<tr>
<td>C4: CHESTERFIELD CENTRAL</td>
<td>46</td>
<td>8.2</td>
<td>2.9</td>
<td>134</td>
<td>6.7</td>
</tr>
<tr>
<td>C5: CENTRAL &amp; SOUTH HARDWICK</td>
<td>52</td>
<td>11.0</td>
<td>6.2</td>
<td>318</td>
<td>14.1</td>
</tr>
<tr>
<td>C6: DALES</td>
<td>49</td>
<td>9.3</td>
<td>8.6</td>
<td>425</td>
<td>19.7</td>
</tr>
<tr>
<td>C7: BUXTON</td>
<td>30</td>
<td>4.1</td>
<td>5.4</td>
<td>162</td>
<td>12.4</td>
</tr>
<tr>
<td>C8: CENTRAL HIGH PEAK</td>
<td>22</td>
<td>3.8</td>
<td>11.5</td>
<td>249</td>
<td>26.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>292</td>
<td>60.3</td>
<td>6.7</td>
<td>1,959</td>
<td>15.4</td>
</tr>
<tr>
<td>% Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

The table above shows the projected travel distance / times (based on an estimate of car travel). This aims to provide a comparative view of how far patients would be treated from their home.

Clearly actual travel times will be influenced by a number of factors (transport method, time of day, etc.).

It shows the average distance as 6.7 miles and total distance as being c.2000 miles.

Proposed:

<table>
<thead>
<tr>
<th>Community</th>
<th># pts</th>
<th>Beds</th>
<th>Avg dist (miles)</th>
<th>Total dist (miles)</th>
<th>Avg time (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: DRONFIELD AND NORTH EAST</td>
<td>16</td>
<td>3.4</td>
<td>6.9</td>
<td>113</td>
<td>15.8</td>
</tr>
<tr>
<td>C2: NORTH HARDWICK AND NORTH EAST</td>
<td>21</td>
<td>4.3</td>
<td>9.8</td>
<td>205</td>
<td>22.4</td>
</tr>
<tr>
<td>C3: CHESTERFIELD EAST</td>
<td>13</td>
<td>2.6</td>
<td>3.5</td>
<td>45</td>
<td>8.1</td>
</tr>
<tr>
<td>C4: CHESTERFIELD CENTRAL</td>
<td>28</td>
<td>5.9</td>
<td>2.4</td>
<td>68</td>
<td>5.4</td>
</tr>
<tr>
<td>C5: CENTRAL &amp; SOUTH HARDWICK</td>
<td>24</td>
<td>4.9</td>
<td>5.1</td>
<td>121</td>
<td>11.7</td>
</tr>
<tr>
<td>C6: DALES</td>
<td>23</td>
<td>4.7</td>
<td>11.7</td>
<td>267</td>
<td>26.7</td>
</tr>
<tr>
<td>C7: BUXTON</td>
<td>10</td>
<td>2.0</td>
<td>23.0</td>
<td>225</td>
<td>52.5</td>
</tr>
<tr>
<td>C8: CENTRAL HIGH PEAK</td>
<td>10</td>
<td>2.2</td>
<td>27.5</td>
<td>289</td>
<td>63.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>145</td>
<td>30.0</td>
<td>9.2</td>
<td>1,332</td>
<td>21.0</td>
</tr>
<tr>
<td>% Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

The table above shows a comparative view of projected travel distance / times based on fewer people (c.50%) being care for in the single ‘centre of excellence’ in Walton.

This shows the average distance for those inpatient care would increase to 9.2 miles but the total distance would be reduced c. 1300 miles (c.30%).

For some communities (Dales, Buxton & Central High Peak i.e. those in proximity to the current sites in Buxton & Newholme), the proposed changes would have more significant impact on the average distance for patients receiving inpatient care.

The cross system evaluation concluded that:

(i) Focusing on a ‘Centre of Excellence’ would out-way the increased travel time for some patients

(ii) From carers/relatives perspective additional travel time could be justified when more specialist care is required in a dedicated unit

Further more detailed analysis is shown in the appendix.
**OPMH – Cost Summary**

The baseline costs of providing bed based care for 243 people in the 3 OPMH units is c.£8.7m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to c. £10.6m. The proposed service model would cost an estimated £9.2m and there is opportunity to reduce this by up to c.£1m if the system is able to rationalise ‘stranded’ costs.

**Baseline:**

<table>
<thead>
<tr>
<th></th>
<th>Baseline (2014-15)</th>
<th>Projected (+5 years) (2019-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>243</td>
<td>292</td>
</tr>
<tr>
<td>Beds</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Costs</td>
<td>£,000s</td>
<td>£,000s</td>
</tr>
<tr>
<td>(i) OPMH bedded care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Walton (30)</td>
<td>5,600</td>
<td>6,813</td>
</tr>
<tr>
<td>- Cavendish (10)</td>
<td>1,650</td>
<td>2,007</td>
</tr>
<tr>
<td>- Newholme (10)</td>
<td>1,450</td>
<td>1,764</td>
</tr>
<tr>
<td>Total</td>
<td>8,700</td>
<td>10,585</td>
</tr>
</tbody>
</table>

The baseline cost of providing bed based care for 243 people with late dementia at times of crisis from 50 beds across 3 units is c.£8.7m per annum. The table shows the costs of each unit.

Growth projections over 5 years would see demand for this service grow to 292 people needing 60 beds at an estimated annual cost of c.£10.6m. This represents an increase in the annual cost of £1.9m.

**Note, costs are based on the baseline levels; no account has been taken of cost inflation.**

**Proposed:**

<table>
<thead>
<tr>
<th></th>
<th>Proposed (+5 years) (2019-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>292</td>
</tr>
<tr>
<td>Beds</td>
<td>30</td>
</tr>
<tr>
<td>Costs</td>
<td>£,000s</td>
</tr>
<tr>
<td>(i) Specialist OPMH (Walton)</td>
<td>5,618 *</td>
</tr>
<tr>
<td>(ii) Dementia Rapid Response Team</td>
<td></td>
</tr>
<tr>
<td>- MH Teams</td>
<td>2,160 *</td>
</tr>
<tr>
<td>- Social Care (support at home)</td>
<td>255 *</td>
</tr>
<tr>
<td>- Drug costs</td>
<td>100</td>
</tr>
<tr>
<td>Total DRRT</td>
<td>2,515</td>
</tr>
<tr>
<td>Total</td>
<td>8,133</td>
</tr>
<tr>
<td>Stranded costs (overheads, site costs)</td>
<td>1,056</td>
</tr>
<tr>
<td>Total (incl. stranded costs)</td>
<td>9,189</td>
</tr>
</tbody>
</table>

The proposed service model would meet the future needs through a combination of:

(i) Specialist Inpatient OPMH Centre of Excellence (Walton) costing an estimated £5.6m; and
(ii) Community Dementia Rapid Response Teams costing an estimated £2.5m. This is comprised of mental health teams (38 wte), social care costs to support people who will no longer be in inpatient beds and estimated drug costs.

The total cost would be c. £8.1m. Further detailed breakdown of the costs is provided in the appendix.

In addition, the proposed changes would ‘strand’ overhead and site costs of c.£1m. The health and care system will need to work together to rationalise these costs. This will be covered within the STP planning by June 2016.
OPMH – Financial benefits

The proposed service would deliver a ‘direct’ annual cost avoidance benefit of £1.4m. Indirect benefits and efficiency opportunities would add to this; they will be included in detailed implementation plans (subject to consultation).

In addition, there is the opportunity to save a further c.£1m by rationalising stranded costs.

Direct cost benefits

The cost analysis on the previous page shows that if we continued with the same service model, in 5 years annual costs would rise to c. £10.6m. The proposed model has an estimated cost of c. £9.2m showing an annual cost avoidance of £1.4m.

To service forecast demand in 2019-20

<table>
<thead>
<tr>
<th></th>
<th>Current service</th>
<th>Proposed service</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bed based care</td>
<td>Specialist Inpatient OMPH</td>
<td>Dementia Rapid Response Team</td>
</tr>
<tr>
<td>Patient episodes</td>
<td>292</td>
<td>145</td>
<td>147</td>
</tr>
<tr>
<td>Beds</td>
<td>60</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Costs (£,000)</td>
<td>10,585</td>
<td>5,618</td>
<td>2,515</td>
</tr>
</tbody>
</table>

Costs per patient (£,000) 36 39 17 28
Costs per bed (£,000) 176 187

The table above shows the comparative average cost per patient (assuming stranded costs are tackled). It demonstrates how the Dementia Rapid Response Team will provide care for an average £17k per patient which is less than half the cost of the current bed based care (£36k).

Indirect (‘2nd order’) cost benefits

In addition to the direct benefits of delivering the ‘right care in the right setting’, it is expected (and is being demonstrated by other similar services) that the proposed model will deliver better integrated care (‘Joined Up Care’). This will also reduce the number of patient episodes that result in admission to inpatient care (either in an acute hospital or OMPH ward). We are currently unable to estimate the scale of this benefit. It would however be measured as a critical success factor for the new service model.

Efficiency

Costs have been estimated on the basis of existing workforce roles in health and social care. There is the opportunity and need to develop our workforce across organisation and role boundaries to create more broadly skilled provision.

In addition, there is opportunity to make better use of technology both to ensure efficient co-ordination and provision of care and to improve the monitoring of patients.

The proposed costs in the business case do not rely on these opportunities. These would however be planned into implementation and commissioning arrangements – targeting an improvement of say 20% over the 5 years.

Further consideration will also be required to determine how the benefits of the efficiency improvements will be realised (e.g. cost saving or delivering more care).

Cost inflation

As previously noted, costs are based on the baseline levels and no account has been taken of cost inflation either in estimating the projected costs with the same model of care or in the proposed model.

Clearly, more detailed implementation and commissioning plans will account for this alongside the efficiency opportunities described.

Stranded costs

The ‘stranded’ overhead and site costs identified of c.£1.056m (£500k management overhead and £556k site rationalisation) presents a further opportunity.

Implementation costs

The cost of implementation and the phasing are described in the following pages.
OPMH – workforce changes

Whilst overall the proposals would result in a small (c. 7%) reduction in overall number of health staff (WTEs), there would be a significant change in the skill mix required (fewer nurses but more specialists and therapists). There would also be an increase (c.7 WTEs) in the numbers of additional social care workers to support c.150 people being cared for at home instead of in hospital.

Current:

<table>
<thead>
<tr>
<th>Role</th>
<th>Specialist OPMH wte</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Manager</td>
<td>1.0</td>
</tr>
<tr>
<td>Ward sister</td>
<td>4.0</td>
</tr>
<tr>
<td>Reg Nurse</td>
<td>54.3</td>
</tr>
<tr>
<td>HCA</td>
<td>64.5</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>4.1</td>
</tr>
<tr>
<td>Ward Clerk</td>
<td>3.3</td>
</tr>
<tr>
<td>Physio</td>
<td>1.6</td>
</tr>
<tr>
<td>Occ Therapist</td>
<td>1.8</td>
</tr>
<tr>
<td>Therapy Support</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total WTE</strong></td>
<td><strong>137.0</strong></td>
</tr>
</tbody>
</table>

The table above shows the current direct staffing of the 3 OPMH wards (Walton Cavendish & Newholme).

Proposed:

<table>
<thead>
<tr>
<th>Role</th>
<th>Specialist OPMH wte</th>
<th>Diff vs current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Manager</td>
<td>1.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Ward sister</td>
<td>4.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Reg Nurse</td>
<td>25.6</td>
<td>-28.7</td>
</tr>
<tr>
<td>HCA</td>
<td>43.6</td>
<td>-20.9</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>1.3</td>
<td>-2.7</td>
</tr>
<tr>
<td>Ward Clerk</td>
<td>1.0</td>
<td>-2.3</td>
</tr>
<tr>
<td>Physio</td>
<td>1.4</td>
<td>-0.2</td>
</tr>
<tr>
<td>Occ Therapist</td>
<td>1.4</td>
<td>-0.4</td>
</tr>
<tr>
<td>Therapy Support</td>
<td>2.8</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total WTE</strong></td>
<td><strong>82.1</strong></td>
<td><strong>-54.8</strong></td>
</tr>
</tbody>
</table>

The table above shows the proposed health care staffing to support the proposed model, including the forecast 20% increase in demand.

The table highlights:

- A reduction in the overall numbers of nurses.
- A increase in the numbers of therapists required.
- Additional specialist skills in the DRRT.

The transition from ward based care to providing care at home presents a number of workforce development challenges described later in this section.

The proposal also includes additional direct social care staff (not shown in the table) c. 7 WTEs to deliver care at home (for the average 50 day period that the patient would otherwise have been in hospital).
OPMH – Outline implementation plan

The proposal would see a reduction in the number of OPMH beds from 50 in 2014/15 to 30 by 2018 provided in a single centre of excellence at Walton. During this time, alternative care to support people at home will be developed through the Dementia Rapid Response Team.

Phasing of implementation

Transition from a bed based model to a community based model will require careful planning. The intention will be to redeploy expertise from the inpatient services to the community. Experience elsewhere in Derbyshire has demonstrated that this can be achieved and will result in a rapid reduction of the need for bed based care.

Consequently, this suggests that the level of double running will be minimal.

The intention is to rapidly ‘ramp down’ the bed based capacity in Cavendish and Newholme (represented in the table below as ‘(iii) other existing direct OPMH wards’).

Phasing of costs

The table below represents the projected costs based on maintaining the current model, the proposed service costs and the stranded overhead and site costs.

The difference between the proposed costs and both the projected costs & baseline are also highlighted – assuming that the stranded cost remain. This is clearly not the intention but is subject to planning how this will be rationalised. This will be covered within the STP planning.

The assumptions underpinning the financial analysis assume a period of 6 months double running as the current beds are decommissioned and the DRRT is implemented.

This is shown in year 1 of the plan where a £0.4m of investment is required in DRRT. Against the baseline position, this shows a net investment of £0.4m.

<table>
<thead>
<tr>
<th></th>
<th>Baseline £,000s</th>
<th>Year 1 £,000s</th>
<th>Year 2 £,000s</th>
<th>Year 3 £,000s</th>
<th>Year 4 £,000s</th>
<th>Year 5 £,000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPMH bedded care</td>
<td>8,700</td>
<td>8,700</td>
<td>9,048</td>
<td>9,410</td>
<td>9,786</td>
<td>10,178</td>
</tr>
<tr>
<td>Growth on baseline</td>
<td>0</td>
<td>348</td>
<td>362</td>
<td>376</td>
<td>391</td>
<td>407</td>
</tr>
<tr>
<td>Projected cost (same service)</td>
<td>8,700</td>
<td>9,048</td>
<td>9,410</td>
<td>9,786</td>
<td>10,178</td>
<td>10,585</td>
</tr>
<tr>
<td>Proposed service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Specialist OPMH (Walton)</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
</tr>
<tr>
<td>(ii) Dementia Rapid Response Team</td>
<td>416</td>
<td>1,588</td>
<td>2,351</td>
<td>2,433</td>
<td>2,515</td>
<td></td>
</tr>
<tr>
<td>(iii) Other existing direct OPMH ward costs</td>
<td>2,000</td>
<td>1,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total proposed service</td>
<td>8,034</td>
<td>8,206</td>
<td>7,969</td>
<td>8,051</td>
<td>8,133</td>
<td></td>
</tr>
<tr>
<td>Stranded Other overheads, site costs</td>
<td>1,056</td>
<td>1,056</td>
<td>1,056</td>
<td>1,056</td>
<td>1,056</td>
<td></td>
</tr>
<tr>
<td>Total (incl. stranded costs)</td>
<td>9,090</td>
<td>9,262</td>
<td>9,025</td>
<td>9,107</td>
<td>9,189</td>
<td></td>
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<tr>
<td>Difference to projected costs</td>
<td>42</td>
<td>-148</td>
<td>-762</td>
<td>-1,071</td>
<td>-1,396</td>
<td></td>
</tr>
<tr>
<td>Difference to baseline (£8,700k)</td>
<td>390</td>
<td>562</td>
<td>325</td>
<td>407</td>
<td>489</td>
<td></td>
</tr>
</tbody>
</table>
OPMH – Outline implementation plan

Moving from ward based care to more community based care presents significant workforce development challenges. One of the key aims will be to redeploy existing staff wherever possible. Transitional costs including training and any redundancy costs are still to be defined.

Workforce development challenges

Workforce transition and development in moving from a bed based model to a community based model will be critical to the success of the proposed changes. One of the key aims will be to redeploy existing staff within the system wherever possible.

Across both Health and Social Care organisations we will need to retain staff during the ‘management of change’ process. There are a number of risks which will need to be managed:

• Risk that staff will choose to apply for other alternatives to leave this workforce before or during the change process.
• Ability to staff inpatient (bedded care) areas as we (i) develop DRRT and (ii) provide suitable alternative employment
• Ability to retain and re-deploy all of our existing registrant workforce
• Consolidation of existing workforce to provide access to Psychiatrist workforce across seven days
• Ability to redeploy our current workforce as not all staff may transfer to the new location if unable to travel
• Recruitment and retention of our support workforce who may not be able to travel to new location
• Ability re-deploy all of our existing support workforce as there may be a risk of redundancy for some staff groups

There are also known underlying general and specific pressures:

• Recruitment and retention of Registered Mental Health Nurses - there is a national supply issue
• Recruitment and retention of AHP workforce - new graduates are not being retained in the East Midlands
• Ageing workforce which may seek retirement

And, there are workforce development challenges / opportunities:

• As we increase the number of staff who take on Specialist and /or Advanced Clinical roles, we need to have an increased supply (succession) of registrant workforce

• The proposed model will require staff to work in a more autonomous fashion than in an inpatient setting – staff will need to be developed and supported so that they can work autonomously
• Opportunity to develop a centre of excellence for teaching and training of future workforce supply
• Opportunity to consider rotation posts across Mental health services, countywide

An overall outline explanation of how we would tackle the combined workforce development challenges considering all of the proposals is covered in a subsequent section – ‘Workforce Planning’.

Transitional costs

As stated previously, the current plan assumes that wherever possible, the current workforce will be redeployed within the system. Consequently, the plan does not yet make provision for redundancy costs. In the light of the workforce development challenges outlined, this will be subject to further ongoing review.

Workforce development, including training will be required to effectively meet the challenges outlined; detailed implementation plans still need to be developed and costed and will be subject to the results of public consultation.

Implications of the changes for other services

The changes present a challenge and opportunity to consider how other community services currently delivered from the sites affected are delivered locally within the communities in the future.

This is the subject of a separate part of this business case.
OPMH – Benefits and Implications Summary

The proposed changes would see more older people with dementia who develop challenging behaviours cared for at home/the place they call home, thus reducing the demand for specialist older persons mental health beds from 50 to 30. This would be beneficial to patients given the negative impacts, both physical and mental, that can occur during admissions and would deliver a ‘direct’ annual cost avoidance benefit of £1.4m, with the potential for more to be added.

Quality benefits
- For those older people with dementia who develop behavioural or psychological symptoms in dementia (BPSD) the default care setting for all patients should be the place they call home as this can significantly improve the quality of care received due to a reduced likelihood of the negative impacts on both physical and mental health during a hospital admission. These include increased risks of falls and urinary tract infections, greater cognitive impairment as a result of taking people out of their usual place of residence, decompensation due to care received reducing levels of activity, increased risk of depression due to isolation and a return to home becoming impossible for some.
- The proposed service change would see half of those people who are currently admitted to a specialist older persons mental health bed when they develop (BPSD) cared for at home / the place they call home. This would be by a community based team known as a Dementia Rapid Response Team in each of the eight communities across North Derbyshire.
- For those who’s care needs are greater than can safely be cared for at home will be cared for in a single ‘Centre of Excellence’ inpatient unit that supports the whole of North Derbyshire.

Financial benefits
- The baseline costs of providing bed based care for 243 people in the 3 OPMH units is c.£8.7m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to c. £10.6m.
- The proposed service would deliver a ‘direct’ annual cost avoidance benefit of £1.4m. Indirect benefits and efficiency opportunities would add to this; they will be included in detailed implementation plans (subject to consultation).
- In addition, there is the opportunity to save a further c.£1m by rationalising stranded costs.

Workforce implications
- Whilst overall the proposals would result in a small (c. 7%) reduction in overall number of health staff (WTEs), there would be a significant change in the skill mix required (fewer nurses but more specialists and therapists).
- There would also be an increase (c.7 WTEs) in the numbers of additional social care workers to support c.150 people being cared for at home instead of in hospital.

Other community service implications
- The proposed model of care would see the closure of the older persons mental health beds currently provided in the community hospitals at Cavendish and Newholme.
- The significant changes in the community hospital bed base presents a challenge and opportunity to consider how other community services currently delivered from those sites are delivered locally within the communities in the future.
- As part of the community hub development, the intention is to continue to deliver services locally – matched to the community needs.
- A complete ‘inventory’ of the services delivered is being prepared to inform options and proposals for how these services could be delivered.

So what is being proposed (subject to consultation)...

The proposals would see a reduction in the number of specialist older persons mental health beds from 50 in 2014/15 to 30 by 2017/18. During this time, this will be achieved through a combination of:

(i) Establishing a Specialist Inpatient OPMH Centre of Excellence (Walton);
(ii) Investing in Community Dementia Rapid Response Teams to work across each of the eight communities; and
(iii) Closing the current OPMH beds at Cavendish and Newholme.
Older Persons Mental Health (OPMH) Day Unit Services

The sub-section contains:
- Service scope covered by the proposals
- Summary of the case for change
- Description of the evaluation process
- Proposed service changes
- Travel access comparison
- Current and proposed service costs
- Financial benefits
- Outline of the workforce changes
- Outline of how the implementation may be phased
- Summary of the benefits and implications
Older People’s Mental Health Day Unit Services - scope

Older peoples mental health services in broad terms are required to meet two distinct needs (i) those related to disease of the brain, primarily (but not exclusively) dementia and (ii) those related to how the brain functions, for example depression, anxiety, psychosis. The focus of proposed service changes described in the remainder of this section are mainly on services that support people generally with low to medium levels of clinical risk associated with their dementia.

Older People’s Mental Health Day Units

As described earlier, Dementia presents a significant challenge to the local health and social care system given people affected by dementia and their families and carers often face difficulties in trying to live well with dementia (see previous chapter for detail).

In North Derbyshire, Older People’s Mental Health Day Units have traditionally provided assessment, treatment and therapy for people with generally lower levels of clinical risk associated with dementia through two services:

**Organic assessment (c. 250 (45%) patients)** – An individual attends 1 or 2 days a week during which a holistic assessment of their needs is carried out and a treatment plan agreed. On average support is for up to 8 weeks, although this could be extended.

People accessing this service are most likely to be those with low to medium levels of clinical risk associated with their dementia. The service may see some individual’s with higher levels of clinical risk however, in these cases, they would need to be of a character that would enable them to be treated in the day unit.

**Living well with Dementia Programmes (LWWD) (c. 209 (38%) patients)** – These have been operating for a number of years. They offer a supportive 12 week programme to both the person suffering from dementia and their carer and include many people who may have only recently received their diagnosis of dementia. LWWD sit naturally with Memory Assessment and Diagnosis pathways and provide a valuable mix of support, information giving, self-health education, signposting to other services, and preparing for the future.

In addition to the core dementia services, the Day Units also provide supplementary support in three further ways:

**Functional illness support (c. 94 (17%) patients)** – Anxiety management and depression support at the request of primary and secondary care services. Theses are not aimed at people with complex functional illness who have very high levels of clinical risk; rather they aim to provide support to people in employing strategies which will improve their mental well-being and therefore, resilience to the types of psycho-social factors that may impact negatively on their lives.

**Other activities** - These include physical health screening, phone calls to other providers to support care e.g. social services, sign-posting to patients and relatives, education sessions and promotion of other community services.

**Respite** – Whatever service an individual might attend, because they are travelling away from their home, by default the informal carer is also experiencing respite.

Scope of proposed services changes

The scope of the proposed service changes described in this section relate to all areas of support delivered by the Day Units. For those people with Dementia, in Derbyshire Dementia Pathway terms it is those people in Phases 3 and 4.

The Day Units are currently provided across three facilities:
(i) Leahurst Day Unit: Walton Community Hospital in Chesterfield
(ii) Stanton Day Unit: Newholme Community Hospital in Bakewell
(iii) Moorfields Day Unit: Bolsover Community Hospital in Bolsover
OPMH Day Units Services – why change?

Although those attending day hospitals clearly benefit, there are some issues with the delivery of the services from central, ‘bricks and mortar’ sites...

Improving the quality of care:

- Specific specialist assessment to examine how the illness is impacting on the person’s ability to safely manage their life and meet their day to day needs is better made in the person’s own home environment.

- Research into ways of supporting people with dementia indicates that care and treatment within the local community offer better outcomes for more people.

- We know that whilst carers feel the benefit of the person attending all day often the person with dementia would prefer to attend for a morning or an afternoon and staying all day can make them anxious about a return home.

- For people who have other mental health disorders (e.g. depression or anxiety) having treatment at the day hospital can be beneficial, but the social opportunity that the day hospital offers can lead to individuals quickly becoming very dependent and reluctant to leave when treatment is complete. This makes it much harder for them to become part of their local community and complete their recovery from mental ill-health.

- There is opportunity to better integrate care currently provide by day units.

Improving take up of services:

- The Living Well With Dementia (LWWD) programme is vital to the progress of people newly diagnosed with dementia and government guidance underlines the importance of the programme being available to people close to the time they are diagnosed.

- Everyone diagnosed with early stage dementia at Memory Assessment Service (MAS) is offered the LWWD programme but for many absorbing the initial impact of the diagnosis is enough and they don’t take up this immediate offer. Consequently, less than a third of people diagnosed with dementia through MAS then take up the offer of the LWWD programme.

- LWWD programme is then likely to be offered again when the person next comes into contact with services which may be a year or two later by which point they may have much more difficulty benefitting from the information and education the group delivers.

Improving access to services:

- Many people are reluctant to travel to the central day hospital and may be worried about mixing with people at the day hospital who they perceive have a more advanced dementia.

- The function of the day hospital as an alternative to hospital admission is difficult to implement, often the person may be too unwell to travel to the central site, or is unable to tolerate being with a large group of other people.

- Safety of the person and risk to others in the day hospital environment can sometimes preclude the day hospital being used as an alternative to hospital admission.

#JoinedUpCare
- keeping people
  ✓ Safe and healthy
  ✓ At Home
  ✓ Independent
Older Person’s Mental Health Day Unit Services – option evaluation

The proposed service changes for older peoples mental health day units are the result of reviewing the current approach to delivering these services in light of the proposed new delivery model for Older Person’s Mental Health Dementia beds and Dementia Rapid Response Team, and feedback from stakeholders.

- **OPMH beds evaluation process**
  - **Proposed new delivery model for OMPH beds and DRRT**
    - Signed off by Clinical and Professional Working Group
    - Signed off by Programme Delivery Group
  - **Consideration of feedback from stakeholders**
    - Agreement further work required by Community Hub Working Group and Programme Delivery Group
  - **Options for alternative models of care for OPMH Day Unit services**
    - Discussed with Community Hubs Working Group
  - **Preferred model of care for OPMH Day Unit services**
    - Signed off by Clinical and Professional Working Group
    - Signed off by Programme Delivery Group

- Questions from stakeholders how proposed delivery model for OPMH beds and DRRT related to/impacted on Day Units
- Day Unit Working Group reviewed current model of care, considered best practice and identified alternatives
- Day Unit Working Group identify preferred model
**OPMH Day Units Services – service description of proposed new delivery model**

The proposed range of services better meet the functions delivered from the day units. They will be more accessible as they will be delivered either within the patient’s own home or from local community facilities. Moreover, the proposed services will be more integrated with other community service provision. These are summarised in the table below and further described on subsequent pages:

<table>
<thead>
<tr>
<th>Current Functions: (Delivered within bricks and mortar day hospital)</th>
<th>Proposed Community based alternatives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Organic Assessment</td>
<td>GP supported by Dementia Support Worker</td>
</tr>
<tr>
<td>CMHT (incl. DCC rapid response team (Bols/Chesterfield))</td>
<td></td>
</tr>
<tr>
<td>Dementia Rapid Response Team (Secondary Care)</td>
<td></td>
</tr>
<tr>
<td>Memory Assessment Service</td>
<td></td>
</tr>
<tr>
<td>ICS Registered Mental Health Worker</td>
<td></td>
</tr>
<tr>
<td>Dementia Support Worker in Primary Care link to CST/ICT</td>
<td></td>
</tr>
<tr>
<td>Living Well With Dementia</td>
<td>Outreach to community facility (Extra Care, village hall, library); repositioned to front of pathway immediately following diagnosis</td>
</tr>
<tr>
<td>Dementia Support Service commissioned by DCC</td>
<td></td>
</tr>
<tr>
<td>Cognitive Stimulation Therapy</td>
<td>Outreach to community facilities closely linked to LWWD locations</td>
</tr>
<tr>
<td>Physical healthcare monitoring</td>
<td>Use of personal health and social care budgets - pt/carer dictated</td>
</tr>
<tr>
<td>Specific expectation of registered staff in LWWD and CST</td>
<td></td>
</tr>
<tr>
<td>GP supported by CST/ICT</td>
<td></td>
</tr>
<tr>
<td>Carer Assessment</td>
<td>Carers assessment and support to be provided at all levels</td>
</tr>
<tr>
<td>Respite - positive non-commissioned consequence</td>
<td>Revised activities will still give a respite benefit</td>
</tr>
<tr>
<td>Support for people with lower level functional MH needs</td>
<td>Supported engagement in mainstream activities in local communities (reducing dependency)</td>
</tr>
<tr>
<td>Primary care supported by MH involvement through ICS/CST</td>
<td></td>
</tr>
<tr>
<td>ICS Mental Health OT</td>
<td></td>
</tr>
<tr>
<td>CMHT</td>
<td></td>
</tr>
</tbody>
</table>

Carer Assessment and support embedded in all interventions or contacts
OPMH Day Units Services – Organic Assessment

Organic assessment would be provided by a set of services aligned to the individual patients needs...

Current model:
The current DCHS day hospital services were developed over twenty years ago as a means of providing an alternative, for many people with dementia to admission to an acute OPMH bed in order to have their mental health care needs assessed and treated.

Organic assessment continues to constitute the largest element of service delivery across all 3 day hospital services, averaging 73% of the total activity across all sites; some 250 people attended for organic assessment during the last year.

People accessing day hospital based organic assessment/treatment services are most likely to be those with low to medium levels of clinical risk associated with their dementia. The day services may see some individual’s with higher level dementia associated clinical risk however, in these cases, they would need to be of a character that would render them treatable in the day hospital setting and that they would not include persistent levels of violence and aggression to self and others.

Within the 21st C Health care project, lead stakeholders would consider that many of this group of patients requiring assessment and treatment, would most likely, as part of future service models, be suitable for assessment and treatment by a community based Dementia Rapid Response Team.

Proposed:
Specific specialist assessment to examine how the illness is impacting on the person’s ability to safely manage their life and meet their day to day needs.

In the new model this assessment will happen through several means:

- The Dementia Rapid Response Team will have a key role in providing assessment at home where there are signs of crisis and admission to a mental health specialist bed is being considered. (40% of patients)
- Detailed assessment may be undertaken by a member of the Neighbourhood Community Mental Health Team, this will be by a mental health professional – nurse, occupational therapist or psychiatrist for example. Some people who attend the day hospital already have contact with a nurse (called a CPN) from this team. It is envisaged that integrating a new specialist mental health role, at registered professional level would enable this interim assessment function and could relate to both primary care and secondary services, by being part of the Integrated Care Service (ICS). (40% of patients)
- The Memory Assessment Service will undertake a diagnostic assessment where an individual has signs of early stages of dementia. (10% of patients)
- The developing role of the primary care based Dementia Support Worker will be key to how people with dementia, or early signs of dementia are assessed and the GP already has a role in this. (10% of patients)
OPMH Day Units Services – Living Well With Dementia (LLWD) and Cognitive Stimulation Therapy

The proposed LWWD services would provide enhanced services within local communities to support three times as many people as current services, soon after initial dementia diagnosis.

In addition, CST services would be established to further support people with dementia as there condition progresses...

Current model:

LWWD programmes have been operating across all of our day hospitals for a number of years. The programmes offer a supportive 12 week programme to both the person suffering from dementia and their carer(s) and include people recently diagnosed with dementia.

In this way, LWWD programmes naturally sit within the Memory Assessment and Diagnosis pathways; whether this is in association with a specialist secondary care based memory assessment service or one that sits in primary care.

These programmes provide a valuable mix of support, information, public health/self-health education, signposting to other useful services and importantly, enabling people to have the tools to prepare for the future.

In 2014/15 the current LWWD programme supported 209 people; yet it is known that in excess of 800 people were diagnosed with early stage dementia and could have benefited from the programme.

In the last 2 years; recognising that many of our communities were not accessing these programmes; we embarked on a programme of promoting these services with GPs and are now ‘outreaching’ them into a wider number of communities in North East Derbyshire and Chesterfield.

However, ensuring the right people attend at the right time in the existing model is a challenge.

Proposed:

A new model of delivery for LWWD in local communities is envisaged, with the aim of improving uptake of the programme at the right time.

Rather than people having to travel to the day hospital, the service will be delivered in a location closer to home. The staff team delivering this service would be more closely aligned with the service providing diagnosis. The anticipated outcome of which would be that significantly more people diagnosed with dementia would attend the groups nearer to the time that they are diagnosed; thus setting the foundation for living well with dementia.

Once people have attended the programme their care and wellbeing would generally be managed within primary care, with Dementia Support Services such as the Alzheimer’s Society being key to this ongoing process.

For many people this level of support is enough to continue with life with dementia. However, for others, the progression of dementia can lead to additional problems and a need for further services.

The new service model would deliver a treatment called Cognitive Stimulation Therapy (CST), again within the local community. This would most likely be delivered by the same staff running the LWWD Programme. This treatment is an evidence based 14 sessions group therapy programme, which has been shown to benefit people with dementia for up to six months. Where an individual’s needs indicate they could attend the group more than once.

The groups would also provide opportunities to ensure the physical health of people with dementia is screened – primarily involving a check of blood pressure, weight, pulse, and general observations. Hearing and sight could be observed and any concerns relayed back to the GP or referrals to other appropriate professionals made.

The proposed LWWD service would support 600 people p.a.

The proposed CST service would support 300 people p.a.
OPMH Day Units Services – Carer Assessment and Respite
The vital role of carers is fully recognised, as is the need to provide effective support for them. The proposed model will provide at least the equivalent support to the current model through a combination of means aligned to the individual and carers needs...

Current model:
The support carers receive is vital to their wellbeing and that of the person they care for; this is well known.

Carer assessment and support - the ambition is that support is available for carers wherever the person close to them receives the service. Therefore, the support a carer receives from the day hospital service will be the same in the new model as in the current model.

Respite - currently, whatever the particular programme that an individual might attend the day hospital for, because they are travelling to a service provided away from their home by default, the informal carer is also experiencing respite. This element of day hospital cannot be underestimated since it enables many informal carers to derive a break from caring during the day. Patients usually attend the units for whole days; which importantly provides their carers with the time and space to address their own psycho-social care needs and by doing so, improve their own mental well-being; therefore their resilience to cope with labours of caring.

Proposed:
The support a carer receives will be the same in the new model as the current model.

Equally the response to carer need will be available from Derbyshire County Council services, from Memory Assessment Services, from Neighbourhood Community Mental Health Teams, Dementia Support Services and every other point of contact they encounter.

In the new model the opportunity would still exist, albeit for a reduced timespan – half a day.

And, there is a balance to be struck (as it is often the case) that the person who is attending, particularly where they have dementia, is reluctant to attend for a whole day. Anxiety about the return home is a frequent expression, and people can become very upset and believe they are never going home. This is seldom the case where a half day attendance can be offered.

To replace the same level of respite as currently provided (i.e. respite during the other half day support currently offered by the Day Units), two alternative respite arrangements could be offered:

i. By delivering the programmes within Community Care Centres such as Meadow View etc. individuals would be able to attend the day unit for the full day which would allow them to have both a social day service/carer respite and also receive their therapy programme during either the morning or afternoon session.

ii. Some people may prefer to have their respite provided in their own homes.
OPMH Day Units Services – Functional illness support programmes

Functional illness support would be provided in a more integrated and community based way through increased capacity in the ICS and Community Mental Health Teams (CMHT)...

Current model:
The day hospitals provide assessment and therapy for people with mental health needs not related to dementia that are over the age of 65. Support programmes offer anxiety management and depression support at the request of primary and secondary care services.

These services are not aimed at people with complex functional illness who have very high levels of clinical risk; rather, they aim to provide support to people in employing strategies which will improve their mental well-being and therefore, their resilience to the types of psycho-social factors that may impact negatively on their lives.

For example, the programme may look at supporting people to cope with changes in their lives thus improving their capacity to manage their depression and anxiety. The programme might therefore be addressing such changes in a person’s life as physical illness and disability, bereavement, social isolation.

As stated previously whilst this treatment is beneficial, the dependence that day hospitals inadvertently foster through supported social opportunity means that for many attendees withdrawal of the service prompts a return of symptoms such as anxiety or depression. As a result the vital re-engagement with community life and activities is lost and often with it the prospect of a return to full health recovery.

Proposed:
The new model will see Neighbourhood Mental Health Team members working more collaboratively and seeking new opportunities close to home, initially providing the treatment element of care and then in local social groups.

This will also ensure that people are not offered a different service on the basis of age. This function of the service would be delivered by Mental Health specialist Occupational Therapists and sit with the Integrated Care Service.
OPMH Day Units Services – Impact on travel
*Care will be provide either within people’s homes or in centres within local communities. Consequently, people will need to travel less when they are attending group programmes and not at all when supported in their own homes.*

**Current model:**
Patients and carers travel to one of three Day Units located at three community hospitals in Chesterfield, Bolsover and Bakewell.

**Proposed:**
Patients will travel to local community centres within each of the communities for LWWD and CST support.
Organic assessment will be provided within people’s homes.
OPMH Day Units Services – Cost Summary

The baseline costs of providing Day Unit services for c.550 people in the 3 Day Units is c.£1.9m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to c. £2.3m. The proposed service model would cost an estimated £1.5m and there is opportunity to reduce this by up to c. £0.4m if the system is able to rationalise the ‘stranded’ costs.

Baseline:

<table>
<thead>
<tr>
<th></th>
<th>Baseline (2014-15)</th>
<th>Projected (+5 years)</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Contacts</td>
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</tr>
<tr>
<td>Costs</td>
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<td>£,000s</td>
</tr>
<tr>
<td>OPMH Dementia Day Units</td>
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<td></td>
</tr>
<tr>
<td>- Walton</td>
<td>1,131</td>
<td>1,375</td>
</tr>
<tr>
<td>- Bolsover</td>
<td>546</td>
<td>665</td>
</tr>
<tr>
<td>- Newholme</td>
<td>195</td>
<td>237</td>
</tr>
<tr>
<td>Total</td>
<td>1,872</td>
<td>2,277</td>
</tr>
</tbody>
</table>

The baseline cost of providing Day Unit care for 553 people across 3 units is c.£1.9m per annum. The table shows the costs of each unit.

Growth projections over 5 years would see demand for this service grow to 693 people (assuming a similar level of service uptake) resulting in costs of c.£2.3m. This represents an increase in the annual cost of £0.4m.

Note, costs are based on the baseline levels; no account has been taken of cost inflation.

Proposed:

<table>
<thead>
<tr>
<th></th>
<th>Proposed (+5 years) (2019-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>1,072</td>
</tr>
<tr>
<td>Contacts</td>
<td>c.10,000 *</td>
</tr>
<tr>
<td>Costs</td>
<td>£,000s</td>
</tr>
<tr>
<td>(i) Organic assessment</td>
<td>151 **</td>
</tr>
<tr>
<td>(ii) LWWD &amp; CST</td>
<td>538</td>
</tr>
<tr>
<td>(iii) Carer support &amp; respite</td>
<td>234</td>
</tr>
<tr>
<td>(iv) Functional illness</td>
<td>151</td>
</tr>
<tr>
<td>Total</td>
<td>1,073</td>
</tr>
<tr>
<td>Stranded costs (overheads, site costs)</td>
<td>400</td>
</tr>
<tr>
<td>Total (incl. stranded costs)</td>
<td>1,473</td>
</tr>
</tbody>
</table>

* additional LWWD & CST support
** DRRT funded by OPMH changes

Further detail at appendix

The costs of the proposed service model is shown above.

It should be noted that:

i. The proposed services (and costs) actually provide support for significantly more people at an earlier stage in their dementia care by supporting more people through the LWWD programme and offering an enhanced service CST service;

ii. the costs of the DRRT are funded by the proposed changes to Specialist OPMH bedded care and as such are not included above;

The total cost would be c. £1.5m. Further detailed breakdown of the costs is provided in the appendix.

In addition, the proposed changes would ‘strand’ overhead and site costs of c.£0.4m. The health and care system will need to work together to rationalise these costs. This will be covered within the Sustainability and Transformation Plan (June 2016).
OPMH Day Units Services – Financial benefits

The proposed service would deliver a ‘direct’ annual cost avoidance benefit of £0.8m. 
Indirect benefits and efficiency opportunities would add to this; they will be included in detailed implementation plans (subject to consultation).
In addition, there is the opportunity to save a further c.£0.4m by rationalising stranded costs.

Direct cost benefits
The cost analysis on the previous page shows that if we continued with the same service model, in 5 years annual costs would rise to c. £2.3m.
The proposed model has an estimated cost of c. £1.5m offering enhanced access and provision showing an annual cost avoidance of £0.8m.

Indirect (‘2nd order’) cost benefits
In addition to the direct benefits of delivering the ‘right care in the right setting’, it is expected (and is being demonstrated by other similar services) that the proposed model will deliver better integrated care (‘Joined Up Care’). This will also reduce the number of patient crisis episodes that result in admission to inpatient care (either in an acute hospital or OPMH ward). We are currently unable to estimate the scale of this benefit. It would however be measured as a critical success factor for the new service model.

Efficiency
Costs have been estimated on the basis of existing workforce roles in health and social care. There is the opportunity and need to develop our workforce across organisation and role boundaries to create more broadly skilled provision.
In addition, there is opportunity to make better use of technology both to ensure efficient co-ordination and provision of care and to improve the monitoring of patients.
The proposed costs in the business case do not rely on these opportunities. These would however be planned into implementation and commissioning arrangements – targeting an improvement of say 20% over the 5 years.
Further consideration will also be required to determine how the benefits of the efficiency improvements will be realised (e.g. cost saving or delivering more care).

Cost inflation
As previously noted, costs are based on the baseline levels and no account has been taken of cost inflation either in estimating the projected costs with the same model of care or in the proposed model.
Clearly, more detailed implementation and commissioning plans will account for this alongside the efficiency opportunities described.

Stranded costs
The ‘stranded’ overhead and site costs identified of c.£0.6m (£400k management overhead and £200k site rationalisation) presents a further opportunity.

Implementation costs
The cost of implementation and the phasing are described in the following pages.
OPMH Day Units Services – workforce changes

Overall the proposals would suggest a significant reduction in the overall number of health staff (WTEs) supporting equivalent services; this does not take account of the significant increases in the community based teams (DRRT and ICS), proposed elsewhere in the PCBC, and who would be providing a significant proportion of the proposed services.

Current:

<table>
<thead>
<tr>
<th>Role</th>
<th>Day units wte</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing - Band7</td>
<td>1.1</td>
</tr>
<tr>
<td>Nursing - Band6</td>
<td>3.4</td>
</tr>
<tr>
<td>Nursing - Band5</td>
<td>6.4</td>
</tr>
<tr>
<td>OT</td>
<td>4.7</td>
</tr>
<tr>
<td>Therapy support</td>
<td>3.7</td>
</tr>
<tr>
<td>HCA</td>
<td>8.6</td>
</tr>
<tr>
<td>Admin</td>
<td>2.7</td>
</tr>
<tr>
<td>Total WTE</td>
<td>30.6</td>
</tr>
</tbody>
</table>

The table above shows the current direct staffing of the 3 Day Units (Walton Bolsover & Newholme).

Proposed:

<table>
<thead>
<tr>
<th>Role</th>
<th>LWWD/CST wte</th>
<th>CMHT/ICS wte</th>
<th>Total wte</th>
<th>Diff wte</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager/LeadClinician</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Lead nurse/OT</td>
<td>1.2</td>
<td>4.9</td>
<td>6.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>3.7</td>
<td>0.0</td>
<td>3.7</td>
<td>-4.7</td>
</tr>
<tr>
<td>HCA</td>
<td>3.7</td>
<td>3.7</td>
<td>0.0</td>
<td>-3.7</td>
</tr>
<tr>
<td>Admin</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
<td>-1.5</td>
</tr>
<tr>
<td>Total WTE</td>
<td>11.0</td>
<td>4.9</td>
<td>15.9</td>
<td>-14.7</td>
</tr>
</tbody>
</table>

Note: does not include additional DRRT & ICS workforce

The table above shows the proposed health care staffing to support the proposed model, including the forecast 20% increase in demand.

As previously noted, the staffing does not include proposed development of the DRRT.

The table highlights:
• A reduction in the numbers of therapists required.
• A reduction in the number of HCAs.

Other proposals related to development of the DRRT and ICS teams shows the need to significantly increase the numbers of therapists within these teams.

The transition from hospital based care to providing care at home presents a number of workforce development challenges described elsewhere in the PCBC.

The proposal also includes additional respite care provision c.£200k which will need to be staffed.
OPMH Day Units Services – Outline implementation plan

The proposed changes would better meet people’s needs. Consequently, all Day Unit services would be decommissioned within the first year (potentially by June 2017). During this time, using the experience of similar services already developed within North Derbyshire and beyond, all the replacement services including DRRT, LWWD/CST and extension of the CMHT and ICS would be implemented…

Phasing of implementation

Transition from the Day Unit based model to a community based model will require careful planning. The intention will be to redeploy expertise from the Day Unit services to community based services. Experience elsewhere in Derbyshire has demonstrated that this can be achieved rapidly and will result in a rapid reduction of the need for bed based care.

The intention is to rapidly ‘ramp down’ the Day Unit capacity (represented in the table below as ‘OPMH Dementia Day Units’).

Phasing of costs

The table below represents the projected costs based on maintaining the current model, the proposed service costs and the stranded overhead and site costs.

The difference between the proposed costs and baseline are also highlighted – assuming that the stranded cost remain. This is clearly not the intention but is subject to planning how this will be rationalised.

The assumptions underpinning the financial analysis assume a period of 6 months double running as the current Day Units are decommissioned and the new services are ramped up.

A higher level of savings can be seen from year 2 onwards (c.£0.4m) against the baseline position.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
</tr>
<tr>
<td>Current service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPMH Dementia Day Units</td>
<td>1,872</td>
<td>1,872</td>
<td>1,946</td>
<td>2,024</td>
<td>2,105</td>
<td>2,190</td>
</tr>
<tr>
<td>Growth on baseline</td>
<td>0</td>
<td>75</td>
<td>78</td>
<td>81</td>
<td>84</td>
<td>88</td>
</tr>
<tr>
<td>Projected cost (same service)</td>
<td>1,872</td>
<td>1,946</td>
<td>2,024</td>
<td>2,105</td>
<td>2,190</td>
<td>2,277</td>
</tr>
<tr>
<td>Proposed service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPMH Dementia Day Units</td>
<td>600</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(i) Organic assessment</td>
<td>129</td>
<td>134</td>
<td>139</td>
<td>145</td>
<td>151</td>
<td></td>
</tr>
<tr>
<td>(ii) LWWD &amp; CST</td>
<td>230</td>
<td>478</td>
<td>497</td>
<td>517</td>
<td>538</td>
<td></td>
</tr>
<tr>
<td>(iii) Carer support &amp; respite</td>
<td>100</td>
<td>208</td>
<td>216</td>
<td>225</td>
<td>234</td>
<td></td>
</tr>
<tr>
<td>(iv) Functional illness</td>
<td>129</td>
<td>134</td>
<td>139</td>
<td>145</td>
<td>151</td>
<td></td>
</tr>
<tr>
<td>Total proposed service</td>
<td>1,187</td>
<td>954</td>
<td>992</td>
<td>1,032</td>
<td>1,073</td>
<td></td>
</tr>
<tr>
<td>Stranded other overheads, site costs</td>
<td>600</td>
<td>500</td>
<td>400</td>
<td>400</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td>Total (incl. stranded costs)</td>
<td>1,787</td>
<td>1,454</td>
<td>1,392</td>
<td>1,432</td>
<td>1,473</td>
<td></td>
</tr>
<tr>
<td>Difference to projected costs</td>
<td>-159</td>
<td>-570</td>
<td>-713</td>
<td>-758</td>
<td>-804</td>
<td></td>
</tr>
<tr>
<td>Difference to baseline (£1,872k)</td>
<td>-85</td>
<td>-418</td>
<td>-480</td>
<td>-440</td>
<td>-399</td>
<td></td>
</tr>
</tbody>
</table>
OPMH Day Units Services – workforce development

Moving from hospital based care to community based care presents significant workforce development challenges. One of the key aims will be to redeploy existing staff wherever possible. Transitional costs including training and any redundancy costs are still to be defined.

Workforce development challenges

Workforce transition and development in moving from a hospital unit based model to a community based model will be critical to the success of the proposed changes.

One of the key aims will be to redeploy existing staff within the system wherever possible.

Across both Health and Social Care organisations we will need to retain staff during the ‘management of change’ process. There are a number of risks which will need to be managed:

- Risk that staff will choose to apply for other alternatives to leave this workforce before or during the change process.
- Ability to retain and re-deploy all of our existing registrant workforce
- Ability re-deploy all of our existing support workforce as there may be a risk of redundancy for some staff groups

And, there are workforce development challenges / opportunities:

- The proposed model will require staff to work in a more autonomous fashion than in an inpatient setting – staff will need to be developed and supported so that they can work autonomously
- Opportunity to develop a centre of excellence for teaching and training of future workforce supply
- Opportunity to consider rotation posts across Mental health services, countywide

An overall outline explanation of how we would tackle the combined workforce development challenges considering all of the proposals is covered in a subsequent section – ‘Workforce Planning’.

Transitional costs

As stated previously, the current plan assumes that wherever possible, the current workforce will be redeployed within the system. Consequently, the plan does not yet make provision for redundancy costs. In the light of the workforce development challenges outlined, this will be subject to further ongoing review.

Workforce development, including training will be required to effectively meet the challenges outlined; detailed implementation plans still need to be developed and costed and will be subject to the results of public consultation.

Implications of the changes for other services

The changes present a challenge and opportunity to consider how other community services currently delivered from the sites affected are delivered locally within the communities in the future. This is considered in a subsequent sub section of the PCBC.
OPMH Day Units Services – Benefits and Implications Summary

The proposed changes would see more older people with dementia being assessed and cared for at home and within their own communities – improving the quality of this assessment and care. In addition, more people would be supported earlier following diagnosis.

In addition, there would be a ‘direct’ annual cost avoidance benefit of £0.8m...

Quality benefits

• Organic assessment would be provided by a set of services aligned to the individual patients needs.

• Specific specialist assessments to examine how the illness is impacting on the person’s ability to safely manage their life and meet their day to day needs is better done in people’s own homes.

• Proposed LWWD services would provide enhanced services within local communities to support three times as many people as current services, soon after initial dementia diagnosis.

• In addition, new CST services would be established to further support people with dementia as their condition progresses.

• The vital role of carers is fully recognised, as is the need to provide effective support for them. The proposed model will provide at least the equivalent support to the current model through a combination of means aligned to the individual and carers needs.

• Functional illness support would be provided in a more integrated and community based way through increased capacity in the ICS and Community Mental Health Teams (CMHT).

Financial benefits

• The baseline costs of providing Day Unit services for c.550 people in the 3 Day Units is c.£1.9m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to c. £2.3m.

• The proposed service model would cost an estimated £1.5m and there is opportunity to reduce this by up to c.£0.4m if the system is able to rationalise the ‘stranded’ costs.

Workforce implications

• Overall, the proposals suggest a significant reduction in overall number of health staff (WTEs) supporting equivalent services; this does not take account of the significant increases in the community based teams (DRRT and ICS) proposed elsewhere in the PCBC; who would be providing a significant proportion of the proposed services.

Other community service implications

• The proposed model of care would see the closure of the Dementia Day Units in Walton, Newholme & Bolsover.

• The impact and implications for those sites is considered elsewhere within the PCBC.

So what is being proposed (subject to consultation)...

The proposals would see services currently delivered through the Dementia Day Units instead provided through a combination of services either within people’s homes or from sites within their communities.

These services would also be better integrated with other community based services including ICS, DRRT and CMHT.

As a result, Dementia Day Units at Walton, Newholme and Bolsover would no longer be required and would close.
Community bedded care

The sub-section contains:
- Service scope covered by the proposals
- Summary of the case for change
- Description of the evaluation process
- Proposed service changes
- Travel access analysis
- Current and proposed service costs
- Financial benefits
- Outline of the workforce changes
- Outline of how the implementation may be phased
- Summary of the benefits and implications
Community bedded care - scope
Across North Derbyshire there is a growing set of services designed to provide short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged acute hospital stays, inappropriate admissions to acute in-patient care, long-term residential care or continuing care. The longest standing component of this set of services is community bedded care, and it is these community beds that are the focus of the proposed service changes described in this section.

Caring for the elderly who have had an illness or an accident
By far, the group of people most likely to experience prolonged acute hospital stays or inappropriate admissions to acute in-patient care, long-term residential care, or continuing care are the elderly. And with the number of people across North Derbyshire aged over 65 forecast to rise by 12% over the next 5 years, and those over 80 by 16% these pressures on the health and care system will only increase.

Across North Derbyshire, as in many other health and care systems, a network of community beds has been established to tackle these challenges. Around 90% of people admitted to the community beds in North Derbyshire are aged over 75. On the whole the focus being on reducing the time spent in acute hospitals following an admission rather than avoiding the acute episode; 85% of the admissions are what has become known as ‘step down’ in nature.

Following an illness or an accident, once medically stable and not requiring consultant-led medical care, older peoples’ needs can be categorised into three broad groups:

1. Those who will recover quickly and who do not need more than a limited amount of support with rehabilitation and reablement.
2. Those who will take more time and need more intensive support with rehabilitation and reablement, which may include access to specialist capabilities.
3. Those whose recovery will be limited, and who will need palliative, continuing or long term residential care.

On the whole, the focus of the community beds across North Derbyshire has been and still is on groups 1 and 2. However, over the last 10 years with greater investment in wider community based services; more significantly an ongoing focus on reducing the time elderly people spend in a hospital bed, the number of community beds serving these needs has reduced to 125 in the same period.

Scope of proposed services changes
The scope of the proposed service changes described in this section relate to those elderly people who are currently cared for in a community bed, most commonly as a transition between hospital and home after an illness of injury.

These community beds are currently provided across a mixture of community hospital and care home sites. 100 beds are provided from 5 community hospitals (Bolsover, Clay Cross, Cavendish, Whitworth & Newholme) and 25 beds are provided from residential care sites (Stonelow Court, The Grange, Staveley Centre and Goyt Valley).

In total these beds currently care for 1,971 patients a year at a total operating cost of £13.8m, which is equivalent to £7k per patient admitted.
Community bedded care – why change

For those elderly people who require rehabilitation and reability support following an illness or injury, admission to a community bed continues to be a common response across North Derbyshire, particularly for those who are admitted to an acute hospital. The default care setting for all patients should be the place they call home as this can significantly improve the quality of care received due to a reduced likelihood of decompensation.

Improving the quality of care:

• Caring for elderly patients in the place they call home can greatly improve the quality of care received and the outcomes achieved.
• Evidence suggests caring for older people in a hospital bed can often outweigh the benefits of care received due to ‘decompensation’. Decompensation is a loss of confidence and mobility or increased risks of harm, falls, poor nutrition and infection.
• The Emergency Care Improvement Programme (ECIP) reported the impact of bed rest in older people as follows:
  • In first 24 hours
    • muscle strength of 2-5%
    • circulating volume by up to 5%
  • In first 7 days
    • circulating volume by up to 20%
    • VO2 Max by 8-15%
    • muscle strength of 5-10%
    • functional residual capacity (FRC) of 15-30%
    • Skin integrity
• Two separate studies have shown that 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.
• In addition there are isolated single wards in the community hospitals that can be associated with increased clinical risks.

Improving the sustainability of the workforce:

• Across the 5 community hospital sites the majority of the community beds are provided from single stand alone wards, which cause a number of workforce challenges:
  • There is a limited therapy service that is stretched across a number of geographically dispersed facilities.
  • Workforce resilience is supported by bank staffing, which brings with it additional cost pressures to the health and care system.
  • The opportunity to develop a more integrated and combined health and social care workforce is limited.

Improving service effectiveness and efficiency:

• The default care setting for all elderly patients should be the place they call home. Not only is this what most people want, it can improve outcomes and be a more effective use of resources.
• Patients cared for at home or close to home remain connected to their family and carers. Community support remains continuous and the patient is less likely to ‘decompensate’.
• Although people prefer to remain in their own home whenever possible, they are often cared for at ‘levels of care’ which are higher than required to meet their needs. Not only does this go against what most people want, it’s also resource inefficient and increases the risk of iatrogenic (health and care induced) harm. Which in turn increases the likelihood of longer stays or being re-admitted.
• Although the default discharge destination from an acute episode of care should be home, it is acknowledged that some patients will have needs which will place them beyond the thresholds for safe care at home. Therefore a tiered care system will be required that continues to use some community beds, albeit with a shorter length of stay than currently.

#JoinedUpCare - keeping people
✓ Safe and healthy
✓ At Home
✓ Independent

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
Community bedded care—option evaluation

The proposed service changes, presented in this section, are the result of an evaluation process that was designed to enable the Community Hubs workstream to consider, in a structured way, alternative models of care to those that currently exist, the options for delivering these and the preferred way forward for the system.

1. People kept at home and independent wherever possible
2. Improved access to care
3. Improved service effectiveness and efficiency

See Appendix for Full Criteria

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
Community bedded care – service description of proposed new delivery model

The proposed service change would see half of those people who currently receive reablement and rehabilitation support in a community bed, cared for at home / the place they call home by a community based team known as a Community Integrated Care Service (ICS). The remainder will be cared for in a smaller number of local Intermediate Care Beds (also by the ICS) or higher intensity Specialist Rehabilitation Beds.

Needs of elderly people with acute illness or injury are managed by admission to a high acuity centre, the aim being to stabilise them medically as quickly as possible and discharge to keep length of stay as short as possible and minimise impact of decompensation / or needs of elderly patients who are not well enough to remain unsupported at home.

As is:
- Once medically stable if further reablement or rehabilitation support is required

Patients are discharged or ‘stepped-up’ to bedded care in a community hospital ward or care home units.

Proposed new care delivery model:
- Once medically stable if further reablement or rehabilitation support is required

Consistent, differentiated care based on standards, criteria and thresholds delivered as part of a system of tiered care to support people home from acute hospitals or provide ‘step up’ care - the default care setting for all patients should be home however it’s recognised some patients needs will place them beyond the thresholds for safe care at home.

---

Community Beds
- Provided from 5 community hospitals (100 beds) (Bolsover, Clay Cross, Cavendish, Whitworth & Newholme); and specialist community beds (25)

125 beds (As Is)

151 beds (Continue As Is (2019/20))

44 beds

32 beds

Care @home

Local Intermediate Care Beds within 8 communities

Specialist Rehab Beds
- 2 sites – CRH (24) and Cavendish (8)
Community bedded care – service description of proposed new delivery model

Each of the eight communities across North Derbyshire would be supported by a community based Integrated Care Service and have a local provision of Intermediate Care Beds. When the level of need requires a higher intensity of input care will be delivered from two Specialist Rehabilitation Units.

Care at home - Community Integrated Care Service

- Each of the eight communities across North Derbyshire will have a locally based health and social care team (Community Integrated Care Service) working in partnership to provide high quality person centred care focused on reablement and rehabilitation.

- The team will operate 0800-2000, 7 days a week and work in collaboration with primary care and colleagues in the bedding setting in both acute and community to enhance the discharge process, including undertaking home based assessments.

- There will be a single point of contact that will enable triage and prioritisation of each individual’s needs including mobilisation or the most appropriate team member in line with agreed timescales.

- The Integrated Care Service will include Occupational Therapy, Physiotherapy, Social Care, Mental Health Services, Voluntary Services, Community Nursing and other services as required.

- Each team will also be supported by Advanced Clinical Practioners and Community Geriatricians however patients will generally remain under the care of their registered GP who would provide / co-ordinate any longer term ongoing care and support. Members of the team will be co-located in the community they serve where practically possible.

- Support is usually for up to 2 weeks, with a maximum of 6 weeks.

Local Intermediate Care Beds

- For those patients requiring more support than can safely be provided at home each community will have local small ‘home like’ units. Patients in these beds will be supported by the same Community Integrated Care Service that cares for people in their own homes.

- Support is usually for up to 2 weeks, with a maximum of 6 weeks.

Specialist Rehabilitation Beds

- Two units: 24 bedded unit at Chesterfield Royal Hospital and an 8 bedded unit at the Cavendish Community Hospital.

- Two units offer the best balance between the need for specialist capability and enabling the ‘step down’ pathway back to the person’s own community.

- Co-locating specialist rehab beds at CRH enables effective transfer of care.

- The units would provide higher intensity rehabilitation together with 24/7 registered nursing care to support higher acuity patients.

- Care on a unit would be for up to 3 weeks but usually less.

- Discharge (step down) would be supported by the Integrated Care Service.
Community beds – Travel access for community bedded care

Analysis of travel distance for people treated in inpatient care demonstrates that due to having two specialist rehab units, for some people, this will mean they are cared for a longer distance from home.

Overall however, because more people will be cared for at home or in intermediate care beds within their own communities, the total travel will be significantly reduced (c. 60%).

Current model (with forecast 20% growth):

<table>
<thead>
<tr>
<th>Community</th>
<th>Total # pts</th>
<th>Beds</th>
<th>Avg dist (miles)</th>
<th>Total dist (miles)</th>
<th>Avg time (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: DRONFIELD AND NORTH EAST</td>
<td>278</td>
<td>18.7</td>
<td>7.0</td>
<td>1945</td>
<td>16.0</td>
</tr>
<tr>
<td>C2: NORTH HARDWICK AND NORTH EAST</td>
<td>291</td>
<td>19.8</td>
<td>3.5</td>
<td>1018</td>
<td>8.0</td>
</tr>
<tr>
<td>C3: CHESTERFIELD EAST</td>
<td>362</td>
<td>23.4</td>
<td>5.9</td>
<td>2148</td>
<td>13.6</td>
</tr>
<tr>
<td>C4: CHESTERFIELD CENTRAL</td>
<td>302</td>
<td>19.6</td>
<td>6.4</td>
<td>1944</td>
<td>14.7</td>
</tr>
<tr>
<td>C5: CENTRAL &amp; SOUTH HARDWICK</td>
<td>332</td>
<td>20.6</td>
<td>5.2</td>
<td>1726</td>
<td>11.9</td>
</tr>
<tr>
<td>C6: DALES</td>
<td>447</td>
<td>25.1</td>
<td>5.9</td>
<td>2646</td>
<td>13.5</td>
</tr>
<tr>
<td>C7: BUXTON</td>
<td>209</td>
<td>10.8</td>
<td>2.5</td>
<td>526</td>
<td>5.8</td>
</tr>
<tr>
<td>C8: CENTRAL HIGH PEAK</td>
<td>145</td>
<td>7.5</td>
<td>8.5</td>
<td>1231</td>
<td>19.4</td>
</tr>
<tr>
<td>Total</td>
<td>2365</td>
<td>145.5</td>
<td>5.6</td>
<td>13,184</td>
<td>12.7</td>
</tr>
<tr>
<td>% Total</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above shows the projected travel distance / times (based on an estimate of car travel). This aims to provide a comparative view of how far patients would be treated from their home on the basis of the current care model.

Clearly actual travel times will be influenced by a number of factors (transport method, time of day, etc.).

It shows the average distance as 5.6 miles and total distance as being c.13,000 miles.

However, it should be noted that currently patients do not necessarily receive inpatient care in the facility closest to their home.

Proposed:

<table>
<thead>
<tr>
<th>Specialist rehab units (CRH &amp; Cavendish)</th>
<th>Total # pts</th>
<th>Beds</th>
<th>Avg dist (miles)</th>
<th>Total dist (miles)</th>
<th>Avg time (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: DRONFIELD AND NORTH EAST</td>
<td>56</td>
<td>3.6</td>
<td>7.0</td>
<td>392</td>
<td>15.9</td>
</tr>
<tr>
<td>C2: NORTH HARDWICK AND NORTH EAST</td>
<td>72</td>
<td>4.6</td>
<td>7.3</td>
<td>526</td>
<td>16.7</td>
</tr>
<tr>
<td>C3: CHESTERFIELD EAST</td>
<td>44</td>
<td>2.8</td>
<td>2.6</td>
<td>116</td>
<td>6.0</td>
</tr>
<tr>
<td>C4: CHESTERFIELD CENTRAL</td>
<td>98</td>
<td>6.3</td>
<td>2.8</td>
<td>273</td>
<td>6.3</td>
</tr>
<tr>
<td>C5: CENTRAL &amp; SOUTH HARDWICK</td>
<td>82</td>
<td>5.2</td>
<td>7.1</td>
<td>580</td>
<td>16.3</td>
</tr>
<tr>
<td>C6: DALES</td>
<td>79</td>
<td>5.0</td>
<td>11.3</td>
<td>893</td>
<td>25.9</td>
</tr>
<tr>
<td>C7: BUXTON</td>
<td>34</td>
<td>2.2</td>
<td>2.1</td>
<td>71</td>
<td>4.8</td>
</tr>
<tr>
<td>C8: CENTRAL HIGH PEAK</td>
<td>36</td>
<td>2.3</td>
<td>7.2</td>
<td>259</td>
<td>16.4</td>
</tr>
<tr>
<td>Total</td>
<td>501</td>
<td>32.0</td>
<td>6.2</td>
<td>3,110</td>
<td>14.2</td>
</tr>
<tr>
<td>% Total</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IC beds within each community</th>
<th>Total # pts</th>
<th>Beds</th>
<th>Avg dist (miles)</th>
<th>Total dist (miles)</th>
<th>Avg time (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: DRONFIELD AND NORTH EAST</td>
<td>77</td>
<td>4.9</td>
<td>1.4</td>
<td>112</td>
<td>3.3</td>
</tr>
<tr>
<td>C2: NORTH HARDWICK AND NORTH EAST</td>
<td>99</td>
<td>6.3</td>
<td>2.9</td>
<td>285</td>
<td>6.6</td>
</tr>
<tr>
<td>C3: CHESTERFIELD EAST</td>
<td>61</td>
<td>3.9</td>
<td>2.8</td>
<td>172</td>
<td>6.5</td>
</tr>
<tr>
<td>C4: CHESTERFIELD CENTRAL</td>
<td>135</td>
<td>8.6</td>
<td>4.3</td>
<td>578</td>
<td>9.8</td>
</tr>
<tr>
<td>C5: CENTRAL &amp; SOUTH HARDWICK</td>
<td>112</td>
<td>7.2</td>
<td>3.4</td>
<td>379</td>
<td>7.7</td>
</tr>
<tr>
<td>C6: DALES</td>
<td>108</td>
<td>6.9</td>
<td>5.7</td>
<td>617</td>
<td>13.0</td>
</tr>
<tr>
<td>C7: BUXTON</td>
<td>46</td>
<td>3.0</td>
<td>1.9</td>
<td>86</td>
<td>4.2</td>
</tr>
<tr>
<td>C8: CENTRAL HIGH PEAK</td>
<td>50</td>
<td>3.2</td>
<td>3.5</td>
<td>174</td>
<td>8.0</td>
</tr>
<tr>
<td>Total</td>
<td>689</td>
<td>44.0</td>
<td>3.5</td>
<td>2,403</td>
<td>8.0</td>
</tr>
<tr>
<td>% Total</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The tables above show a comparative view of projected travel distance based on fewer people (c.50%) being cared for in the specialist rehab units and IC beds.

This shows the average distance for people in specialist rehab beds would increase marginally to 6.2 miles; but for people in IC beds the average distance would reduce to 3.5 miles. And, overall the total distance from home would be reduce very significantly to c.5,500 miles (c. 58%).

The only increased distances would be for people in North Hardwick, South Hardwick and Dales when accessing specialist rehab.

More detailed analysis is shown in the appendix.
Community bedded care – cost summary

The baseline costs of providing bed based care for 1,971 people in the Community Hospitals and Intermediate Care beds is £13.4m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to £16.3m. The proposed service model would cost an estimated £10.0m plus £1.7m of stranded costs (£11.7m total). There is opportunity to reduce this by up to £1.7m if the system is able to rationalise ‘stranded’ costs.

<table>
<thead>
<tr>
<th>From</th>
<th>Baseline (2014-15)</th>
<th>Projected (+5 years) (2019-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>1971</td>
<td>2365</td>
</tr>
<tr>
<td>Beds</td>
<td>125</td>
<td>151</td>
</tr>
<tr>
<td>Costs £,000s</td>
<td>£,000s</td>
<td></td>
</tr>
<tr>
<td>(i) Community hospital beds</td>
<td>11,950</td>
<td>14,534</td>
</tr>
<tr>
<td>- Bolsover (32)</td>
<td>2,860</td>
<td>3,478</td>
</tr>
<tr>
<td>- Cavendish (16)</td>
<td>2,180</td>
<td>2,651</td>
</tr>
<tr>
<td>- Clay Cross (16)</td>
<td>2,150</td>
<td>2,615</td>
</tr>
<tr>
<td>- Newholme (16)</td>
<td>2,000</td>
<td>2,432</td>
</tr>
<tr>
<td>- Whitworth (20)</td>
<td>2,760</td>
<td>3,357</td>
</tr>
<tr>
<td>(ii) Intermediate care beds</td>
<td>1,470</td>
<td>1,793</td>
</tr>
<tr>
<td>- Care home beds (25)</td>
<td>850</td>
<td>1,037</td>
</tr>
<tr>
<td>- In reach health care</td>
<td>620</td>
<td>756</td>
</tr>
<tr>
<td>Total</td>
<td>13,420</td>
<td>16,327</td>
</tr>
</tbody>
</table>

The baseline cost of providing community bed based care for 1971 people typically following an acute hospital episode is £13.4m per annum. The table shows the costs of each of the units providing these services.

Growth projections over 5 years would see demand for this service grow to 2365 people needing 151 beds at an estimated annual cost of £16.3m. This represents an increase in the annual cost of £2.9m.

Note, costs are based on the baseline levels; no account has been taken of cost inflation.

<table>
<thead>
<tr>
<th>To</th>
<th>Proposed (+5 years) (2019-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>2365</td>
</tr>
<tr>
<td>Beds</td>
<td>76</td>
</tr>
<tr>
<td>Costs £,000s</td>
<td></td>
</tr>
<tr>
<td>(i) Specialist rehab beds</td>
<td>3,407 *</td>
</tr>
<tr>
<td>- CRH (24)</td>
<td>2,215</td>
</tr>
<tr>
<td>- Cavendish (8)</td>
<td>1,191</td>
</tr>
<tr>
<td>(ii) Local intermediate care beds</td>
<td>2,989</td>
</tr>
<tr>
<td>- Intermediate care beds</td>
<td>1,996</td>
</tr>
<tr>
<td>- In reach from ICS</td>
<td>933</td>
</tr>
<tr>
<td>(iii) Community Integrated Care Service (ICS)</td>
<td>3,598 *</td>
</tr>
<tr>
<td>- Health care input</td>
<td>2,349</td>
</tr>
<tr>
<td>- Social care input</td>
<td>1,249</td>
</tr>
<tr>
<td>Total</td>
<td>9,994</td>
</tr>
<tr>
<td>Changes implemented in 2015/16</td>
<td>1,605</td>
</tr>
<tr>
<td>Stranded costs (overheads, site costs)</td>
<td>1,731</td>
</tr>
<tr>
<td>Total (incl. 15/16 changes &amp; stranded costs)</td>
<td>13,330</td>
</tr>
</tbody>
</table>

The proposed service model would meet future needs through a combination of:

(i) 32 Specialist Rehab Beds provided from 2 units costing an estimated £3.4m;

(ii) 44 Local Intermediate Care beds provided within communities and supported by in reach from ICS costing £3.0m;

(iii) Community Integrated Care Service (ICS) supporting c. 50% of patients within their own homes operating within each local community - costing an estimated £3.6m. This is comprised of integrated social care and health care teams.

The total cost would be c. £10m. Further detailed breakdown of the costs is provided in the appendix.

During 2015/16 steps have already been taken to reduce the existing community bed base. The resultant ‘savings’ (c. £1.6m) have been used to deliver some cost improvement savings and to support additional capacity in the community.

In addition, the proposed changes would ‘strand’ overhead and site costs of c.£1.7m. The health and care system will need to work together to rationalise these costs. This is the subject of a separate section of the business case.
Community bedded care – financial benefits

The proposed service would deliver a ‘direct’ annual cost avoidance benefit of £4.6m (£3.0m net of 15/16 benefits taken). Indirect benefits and efficiency opportunities would add to this; they will be included in detailed implementation plans (subject to consultation). In addition, there is the opportunity to save a further c.£1.7m by rationalising stranded costs.

Direct cost benefits

The cost analysis on the previous page shows that if we continued with the same service model, in 5 years annual costs would rise to c. £16.3m.

The proposed model has an estimated cost of c. £10m plus £1.7m (stranded costs) showing an annual cost avoidance of £4.6m. Note, £1.6m of this benefit has already been delivered in 15/16 so the additional benefit (before tackling the stranded costs) is £3.0m.

To service forecast demand in 2019-20

<table>
<thead>
<tr>
<th>Current service</th>
<th>Proposed service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bed based care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist Rehab Beds</td>
<td>Intermediate Care Beds</td>
</tr>
<tr>
<td>Patient episodes</td>
<td>2,365</td>
<td>501</td>
</tr>
<tr>
<td>Beds</td>
<td>151</td>
<td>32</td>
</tr>
<tr>
<td>Costs (£,000)</td>
<td>16,327</td>
<td>3,407</td>
</tr>
<tr>
<td>Cost per patient (£,000)</td>
<td>6.9</td>
<td>6.8</td>
</tr>
<tr>
<td>Cost per bed (£,000)</td>
<td>108</td>
<td>106</td>
</tr>
</tbody>
</table>

The above shows the comparative average cost per patient. It demonstrates how the proposed services, differentiated to better align to people’s needs can also be delivered more cost effectively.

Indirect (‘2nd order’) cost benefits

In addition to the direct benefits of delivering the ‘right care in the right setting’, the proposed services will deliver better integrated care (‘Joined Up Care’) for people. Indeed the services described will not operate discretely (as represented in the table) but will actually operate in an integrated way within communities and moreover, will be fully integrated with existing community based teams and primary care.

By doing this, the intention is to help to keep people more independent and at home; avoiding / reducing the number of patient episodes including those that result in admission to inpatient health care and / or long term residential or nursing care. We are currently unable to estimate the scale of this benefit. It would however be measured as a critical success factor for the new service model.

Efficiency

Costs have been estimated on the basis of existing workforce roles in health and social care. There is the opportunity and need to develop our workforce across organisation and role boundaries to create more broadly skilled provision.

In addition, there is opportunity to make better use of technology both to ensure efficient co-ordination and provision of care and to improve the monitoring of patients.

The proposed costs in the business case do not rely on these opportunities. These would however be planned into implementation and commissioning arrangements – targeting an improvement of say 20% over the 5 years.

Further consideration will also be required to determine how the benefits of the efficiency improvements will be realised (e.g. cost saving or delivering more care).

Cost inflation

As previously noted, costs are based on the baseline levels and no account has been taken of cost inflation either in estimating the projected costs with the same model of care or in the proposed model.

Clearly, more detailed implementation and commissioning plans will account for this alongside the efficiency opportunities described.

Stranded costs

The ‘stranded’ overhead and site costs identified of c.£1.7m (£750k management overhead and £950k site rationalisation) presents a further opportunity.

Implementation costs

The cost of implementation and the phasing are described in the following pages.
Community bedded care – workforce changes

Whilst overall the proposals would result in a small (c. 8%) reduction in overall health staff WTEs, there would be a significant change in the skill mix required (fewer nurses but more therapists). There would also be a significant increase (c.95 WTEs) in the numbers of additional social workers and care workers to support more people being cared for at home.

Current:

<table>
<thead>
<tr>
<th>Workforce type</th>
<th>Community ward beds WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANP</td>
<td></td>
</tr>
<tr>
<td>Ward Mgr</td>
<td>5.0</td>
</tr>
<tr>
<td>Reg Nurse</td>
<td>59.9</td>
</tr>
<tr>
<td>Healthcare Asst</td>
<td>64.6</td>
</tr>
<tr>
<td>Physio</td>
<td>2.1</td>
</tr>
<tr>
<td>OT</td>
<td>1.8</td>
</tr>
<tr>
<td>Therapy Asst</td>
<td>5.3</td>
</tr>
<tr>
<td>Admin &amp; Clerical</td>
<td>6.2</td>
</tr>
<tr>
<td>Ancillary</td>
<td>7.4</td>
</tr>
<tr>
<td>Dementia Support Worker</td>
<td></td>
</tr>
<tr>
<td>Geriatrician</td>
<td></td>
</tr>
<tr>
<td>Total WTE</td>
<td>152.2</td>
</tr>
</tbody>
</table>

The table above shows the current direct staffing of community wards. This excludes health ‘in reach’ provided to the existing 25 intermediate care beds.

Proposed:

<table>
<thead>
<tr>
<th>Workforce type</th>
<th>Specialist rehab WTE</th>
<th>Diff vs Current</th>
<th>ICS WTE</th>
<th>Total WTE</th>
<th>Diff vs Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANP</td>
<td>1.0</td>
<td>-1.0</td>
<td>6.1</td>
<td>7.1</td>
<td>-1.0</td>
</tr>
<tr>
<td>Ward Mgr</td>
<td>2.0</td>
<td>-3.0</td>
<td>0.0</td>
<td>2.0</td>
<td>-3.0</td>
</tr>
<tr>
<td>Reg Nurse</td>
<td>23.6</td>
<td>-36.2</td>
<td>19.5</td>
<td>43.2</td>
<td>-16.7</td>
</tr>
<tr>
<td>Healthcare Asst</td>
<td>25.1</td>
<td>-39.6</td>
<td>6.9</td>
<td>31.9</td>
<td>-32.7</td>
</tr>
<tr>
<td>Physio</td>
<td>3.0</td>
<td>-0.9</td>
<td>19.1</td>
<td>22.1</td>
<td>20.0</td>
</tr>
<tr>
<td>OT</td>
<td>3.0</td>
<td>-1.2</td>
<td>8.9</td>
<td>11.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Therapy Asst</td>
<td>2.5</td>
<td>-2.8</td>
<td>7.0</td>
<td>9.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Admin &amp; Clerical</td>
<td>2.0</td>
<td>-4.2</td>
<td>0.0</td>
<td>2.0</td>
<td>-4.2</td>
</tr>
<tr>
<td>Ancillary</td>
<td>2.0</td>
<td>-5.4</td>
<td>0.0</td>
<td>2.0</td>
<td>-5.4</td>
</tr>
<tr>
<td>Dementia Support Worker</td>
<td>0.0</td>
<td>0.0</td>
<td>7.5</td>
<td>7.5</td>
<td>7.5</td>
</tr>
<tr>
<td>Geriatrician</td>
<td>0.0</td>
<td>0.0</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total WTE</td>
<td>64.2</td>
<td>-88.0</td>
<td>76.2</td>
<td>140.3</td>
<td>-11.8</td>
</tr>
</tbody>
</table>

The table above shows the proposed health care staffing to support the proposed model including the forecast 20% increase in demand.

The ICS team would support both in reach into the IC beds and care at home.

The table highlights:
• A reduction in the overall numbers of nurses but higher skill levels.
• A significant increase in the numbers of therapists required.

The transition from ward based care to providing care at home or within local community intermediate care beds presents a number of workforce development challenges described later in this section.

The proposal also includes additional direct care staff (not shown in the table):

i) To deliver care in the 19 additional local intermediate care beds (c. 40 WTEs).

ii) To deliver care at home (working integrated with the health staff as part of ICS) including social workers and care workers (c. 55 WTEs).
Community bedded care – outline implementation plan

The proposal would see a reduction in the number of community hospital beds from 100 in 2014/15 to 32 by 2017/18. During this time, alternative care will be developed through: (i) Local intermediate care beds which will be increased from 25 to 44 beds; (ii) Integrated Care Service (ICS) will be further developed to support an additional 1,175 people per annum.

Phasing of implementation

The proposed model would see a reduction in the number of community hospital beds from 100 in 2014/15 to 32 by 2017/18. During this time, alternative care will be developed through:

(i) Local intermediate care beds which will be increased from 25 to 44 beds, with an additional investment of £1.15m in local care beds plus £0.4m in reach care through ICS.

(ii) Integrated Care Service (ICS) will be further developed to support an additional 1,175 people per annum by investing £2.35m in health resources and £1.25m in social care.

Consequently, this transition will see a significant additional investment in social care services £2.4m.

As part of this transition, it is proposed that a 24 bedded specialist rehabilitation ward / unit be developed on the Chesterfield Royal Hospital site with a further 8 beds being housed at the Cavendish Hospital in Buxton. The overall cost of the Intensive Rehab beds is estimated to be £3.4m. This is phased to be operational in year 2 of the plan.

Phasing of costs

The table below represents the projected costs based on phasing out the current model, the introduction of the proposed service and identifies the stranded overhead and site costs.

The difference between the proposed costs and both the projected costs and baseline are also highlighted – assuming that the stranded cost remain.

It is clearly the intention to tackle the stranded costs but is subject to planning how this will be achieved. This will be covered within the STP planning by June 2016.

The assumptions underpinning the financial analysis assume a period of 6 months double running as the current community beds are decommissioned and the alternative services are fully developed.

This is shown in year 1 of the plan where an additional £1.4m of investment is required in ICS, against a revised baseline position (taking account of the £1.6m savings in 15/16); this shows a net investment of £1.3m.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 5 Revised implementation considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
</tr>
<tr>
<td>Current service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community bedded care</td>
<td>13,424</td>
<td>13,424</td>
<td>13,961</td>
<td>14,519</td>
<td>15,100</td>
<td>15,704</td>
</tr>
<tr>
<td>Growth on baseline</td>
<td>0</td>
<td>537</td>
<td>558</td>
<td>581</td>
<td>604</td>
<td>628</td>
</tr>
<tr>
<td>Projected cost (same service)</td>
<td>13,424</td>
<td>13,961</td>
<td>14,519</td>
<td>15,100</td>
<td>15,704</td>
<td>16,331</td>
</tr>
<tr>
<td>Proposed service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Specialist rehab beds</td>
<td>0</td>
<td>2,337</td>
<td>3,407</td>
<td>3,407</td>
<td>3,407</td>
<td></td>
</tr>
<tr>
<td>(ii) Local intermediate care beds</td>
<td>1,696</td>
<td>2,846</td>
<td>2,892</td>
<td>2,940</td>
<td>2,989</td>
<td></td>
</tr>
<tr>
<td>(iii) Community Integrated Care Service (ICS)</td>
<td>1,430</td>
<td>2,888</td>
<td>3,326</td>
<td>3,460</td>
<td>3,598</td>
<td></td>
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<tr>
<td>(iv) Other existing direct bedded care costs</td>
<td>7,503</td>
<td>1,730</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total proposed service</td>
<td>10,629</td>
<td>9,801</td>
<td>9,624</td>
<td>9,806</td>
<td>9,994</td>
<td>9,260</td>
</tr>
<tr>
<td>Stranded other overheads, site costs</td>
<td>2,509</td>
<td>1,942</td>
<td>1,766</td>
<td>1,749</td>
<td>1,731</td>
<td></td>
</tr>
<tr>
<td>Total (incl. stranded costs)</td>
<td>13,138</td>
<td>11,742</td>
<td>11,390</td>
<td>11,555</td>
<td>11,725</td>
<td>11,860</td>
</tr>
<tr>
<td>Difference to projected costs</td>
<td>-823</td>
<td>-2,777</td>
<td>-3,710</td>
<td>-4,149</td>
<td>-4,606</td>
<td>-4,471</td>
</tr>
<tr>
<td>Difference to baseline (£13,424k)</td>
<td>-286</td>
<td>-1,682</td>
<td>-2,034</td>
<td>-1,869</td>
<td>-1,699</td>
<td>-1,564</td>
</tr>
<tr>
<td>Difference to revised 15/16 baseline (£11,819k)</td>
<td>1,319</td>
<td>-77</td>
<td>-430</td>
<td>-264</td>
<td>-94</td>
<td>41</td>
</tr>
</tbody>
</table>
Community bedded care – implementation implications
Moving from ward based care to significantly more care being delivered at home or within local community intermediate care beds presents significant workforce development challenges. One of the key aims will be to redeploy existing staff wherever possible. Transitional costs including training and any redundancy costs are still to be defined.

Workforce development challenges
Workforce transition and development in moving from a bed based model to a community based model will be critical to the success of the proposed changes. One of the key aims will be to redeploy existing staff wherever possible.

Across both Health and Social Care organisations we will need to retain staff during the ‘management of change’ process. There are a number of risks which will need to be managed:

- Risk that staff will choose to apply for other alternatives to leave this workforce before or during the change process.
- Ability to staff inpatient (bedded care) areas as we (i) develop ICS and (ii) provide suitable alternative employment
- Targeted recruitment to meet proposed therapy staffing levels
- Ability of Social Care to attract, recruit and retain care assistant workforce
- Ability to retain and re-deploy necessary registrant workforce
- Ability to redeploy our current workforce as not all staff may transfer to the new location if unable to travel
- Ability re-deploy all of our existing support workforce as there may be a risk of redundancy for some staff groups

There are also known underlying general and specific pressures:

- Recruitment and retention of Registered Nurses - there is a national supply issue
- Recruitment and retention of AHP workforce - new graduates are not being retained in the East Midlands
- Ageing workforce which may seek retirement

And, there are workforce development challenges / opportunities:

- Opportunity to develop support workforce in partnership with DCC and to flex as required
- As we increase the number of staff who take on Specialist and /or Advanced Clinical roles, we need to have an increased supply (succession) of registrant workforce

• The proposed model will require staff to work in a more autonomous fashion than in an inpatient setting – staff will need to be developed and supported so that they can work autonomously

An overall outline explanation of how we would tackle the combined workforce development challenges considering all of the proposals is covered in a subsequent section – ‘Workforce Planning’.

Transitional costs
As stated previously, the current plan assumes that wherever possible, the current workforce will be redeployed within the system. Consequently, the plan does not yet make provision for redundancy costs. In the light of the workforce development challenges outlined, this will be subject to further ongoing review.

Workforce development, including training will be required to effectively meet the challenges outlined; detailed implementation plans still need to be developed and costed and will be subject to the results of public consultation.

Development of the specialist rehab unit at CRH will require capital investment; estimated to be c.£1.3m.

Implications of the changes
The significant changes in the community hospital bed base presents a challenge and opportunity to consider how other community services currently delivered from those sites are delivered locally within the communities in the future.

This is the subject of a separate part of this business case.
Community bedded care – Benefits and Summary
The proposed changes would see more elderly people being cared for at home/the place they call home, thus reducing the required number of community hospital beds from 100 to 32. This would be beneficial to patients due to a reduced likelihood of decompensation in a hospital bed and would deliver a ‘direct’ annual cost avoidance benefit of £4.6m, with the potential for further benefits to be added.

Quality benefits
- For those elderly people who require rehabilitation and reablement support following an illness or injury, the default care setting for all patients should be the place they call home as this can significantly improve the quality of care received due to a reduced likelihood of decompensation. Decompensation is a loss of confidence and mobility or increased risks of harm, falls, poor nutrition and infection.
- The proposed service change would see half of those people who currently receive reablement and rehabilitation support in a community bed, cared for at home; the place they call home by a community-based team known as a Community Integrated Care Service. The remainder will be cared for in a smaller number of local Intermediate Care Beds (also supported by the Community Integrated Care Service) or higher intensity Specialist Rehabilitation Beds.
- Each of the eight communities across North Derbyshire would be supported by a community-based Integrated Care Service and have a local provision of Intermediate Care Beds. When the level of need requires a higher intensity of input care will be delivered from two Specialist Rehabilitation Units.

Financial benefits
- The baseline costs of providing bed-based care for 1,971 people in the Community Hospitals and Intermediate Care beds is c.£13.4m. If we continued with the same service model, the projected 20% increase in demand over 5 years would see costs rise to c. £16.3m.
- The proposed service model would cost an estimated £10.0m plus £1.7m of stranded costs (£11.7m total).
- The proposed service would deliver a ‘direct’ annual cost avoidance benefit of £4.6m (£3.0m net of 15/16 benefits taken). Indirect benefits and efficiency opportunities would add to this; they will be included in detailed implementation plans (subject to consultation). In addition, there is the opportunity to save a further c.£1.7m if the system is able to rationalise ‘stranded’ costs.

Workforce implications
- Whilst overall the proposals would result in a small (c. 8%) reduction in overall health staff WTEs, there would be a significant change in the skill mix required (fewer nurses but more therapists).
- There would also be a significant increase (c.95 WTEs) in the numbers of additional social workers and care workers to support more people being cared for at home.

Other community service implications
- The proposed model of care would see the closure of the community beds currently provided in the community hospitals at Bolsover, Clay Cross, Newholme and Whitworth.
- The significant changes in the community hospital bed base presents a challenge and opportunity to consider how other community services currently delivered from those sites are delivered locally within the communities in the future.
- As part of the community hub development, the intention is to continue to deliver services locally – matched to the community needs.
- A complete ‘inventory’ of the services delivered is being prepared to inform options and proposals for how these services could be delivered.

So what is being proposed (subject to consultation)...
The proposal would see a reduction in the number of community hospital beds from 100 in 2014/15 to 32 by 2017/18. During this time, alternative care will be developed through:
(i) Local intermediate care beds which will be increased from 25 to 44 beds;
(ii) Integrated Care Service (ICS) will be further developed to support an additional 1,175 people per annum; and
(iii) Closure of community beds currently provided in the community hospitals at Bolsover, Clay Cross, Newholme and Whitworth.
(iv) And, the specialist rehab beds (32) will be delivered from Chesterfield Royal site (24) and Cavendish (8);
Urgent access to care

The sub-section contains:
- Scope of services impacted by the proposals
- Summary of the case for change
- Description of the evaluation process
- Current thinking on service changes
- Conclusions and next steps
Urgent Access to Care – scope

National consultation with patients and the public identified that people do not distinguish between urgent and emergency healthcare needs. Urgent and emergency care needs are those that the patient perceives require a response on the same day that they arise. The patient, not the clinician, judges the urgency of the need prior to any clinical assessment and should not be expected to choose correctly between emergency (time-critical) and urgent (not time-critical) care.

What do we mean by urgent access to care

- Consultation with patients and the public, undertaken during the early phases of the national Keogh Urgent and Emergency Care Review, identified that people do not distinguish between urgent and emergency healthcare needs.
- As an overall guide:
  - Urgent and emergency care needs are those that the patient perceives require a response on the same day that they arise.
  - Same-day responsiveness is an expectation of modern healthcare systems.
  - Judgement of urgent and emergency is made by the patient, and not by a clinician retrospectively; this is because the true urgency of a problem cannot be determined until it has been assessed.
  - Clinicians may choose to distinguish between emergency (time critical) and urgent (not time critical) care, and system nomenclature has adapted accordingly, however patients should not be expected to choose correctly between these options; the system should guide patients to the correct level of care.
- For the purpose of this business case urgent care activity has been divided into four types:
  - Type 1: See and Treat – delivered by the ambulance service, Primary Care in and out of hours, and mental health crisis resolution contacts
  - Type 2: Hear and Treat – delivered by 111, the ambulance service and Primary Care in and out of hours
  - Type 3: Patient Attends – delivered by Primary Care in and out of hours, Minor Injuries Units and Emergency Departments
  - Type 4: Onward referrals – by 111 and the ambulance service

These describe how patients initially access urgent care services. It should be noted the full scope of urgent and emergency services is much wider.

<table>
<thead>
<tr>
<th>Service</th>
<th>Contacts</th>
<th>Cost (£m)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2: Hear and Treat</td>
<td>49,158</td>
<td>within PC contract</td>
</tr>
<tr>
<td>Primary Care In Hours</td>
<td>49,158</td>
<td></td>
</tr>
<tr>
<td>Primary Care Out of Hours</td>
<td>9,447</td>
<td>£0.25</td>
</tr>
<tr>
<td>Other (e.g. NHS111, Ambulance Service)</td>
<td>17,325</td>
<td>£0.35</td>
</tr>
<tr>
<td>Sub-total</td>
<td>75,930</td>
<td>£0.60</td>
</tr>
<tr>
<td>Type 3: Patient Attends</td>
<td>366,451</td>
<td>within PC contract</td>
</tr>
<tr>
<td>Primary Care In Hours</td>
<td>366,451</td>
<td></td>
</tr>
<tr>
<td>Primary Care Out of Hours</td>
<td>22,000</td>
<td>£3.76</td>
</tr>
<tr>
<td>MIU @ Buxton and Whitworth</td>
<td>16,920</td>
<td>£0.94</td>
</tr>
<tr>
<td>New Mills Walk-in Centre</td>
<td>7,250</td>
<td>£0.39</td>
</tr>
<tr>
<td>ED @ Chesterfield Royal Hospital</td>
<td>7,400</td>
<td>£7.77</td>
</tr>
<tr>
<td>Cross Border ED/UCC</td>
<td>8,100</td>
<td>£8.30</td>
</tr>
<tr>
<td>Sub-total</td>
<td>518,021</td>
<td>£16.15</td>
</tr>
<tr>
<td>TOTAL</td>
<td>593,951</td>
<td>£17.35</td>
</tr>
</tbody>
</table>

* The cost is the cost to commissioner to buy the activity

Scope of service changes explored

- The scope of service changes explored in this section specifically relate to a proportion (77%) of Type 2: Hear and Treat urgent care activity (that delivered by Primary Care) and all Type 3: Patient Attends activity.

When describing Primary Care:

- In Hours refers to the core hours general practice operates between 08:00-18:30 Monday to Friday.
- Out of Hours refers to the period 18:30-08:00 Monday to Friday and 24/7 over the weekend and Bank Holidays.
**Urgent Access to Care – local reasons to change**

Locally patients report difficulties accessing General Practice and the desire for a more simple and consistent urgent care system; nationally the Keogh review supports this. 40% of those attending the Emergency Department (ED) at Chesterfield Royal Hospital could be seen in primary care, sustained delivery of the ED wait target is a challenge and a significant number of admissions could be avoided if alternative services existed. The local Minor Injury Units are underutilised; the majority of patients seen have primary care needs, and they contribute to inequitable access across North Derbyshire.

**Improving the quality of care:**
- There is increasing urgent care demand on general practice. Primary Care delivers the majority of urgent care contacts and locally some patients are reporting difficulties in accessing General Practice care when they need it (Survey 2015).
- National guidance (Keogh, 2015 – see appendix) sets out an expectation for an urgent care system which: offers same day responsiveness; guides the patient to the correct level of care reliably 24/7; requires primary and community care to offer a same day response to the majority of urgent care needs, with provision shifting from hospitals to the community.
- Urgent care is often provided without access to the complete medical record.
- Delivery of the 4 hour A&E wait target is a continual pressure and a significant number of admissions from ED could be avoided if alternative services were available e.g. improved triage and assessment, and better knowledge of and access to improved community services.

**Improving the sustainability of the workforce:**
- The GP workforce is decreasing with vacancies in training programmes and in General Practice.
- There is a national shortage of Advanced Nurse Practitioners and a two year training programme.
- OOH providers in primary care and in the acute hospitals report difficulty in recruiting to vacant posts, in retaining qualified staff and in covering some shifts.
- Keogh standards will require Urgent Care Centres which have access to diagnostics & staff 16 hours / day, 7 days a week.

**Improving service effectiveness and efficiency:**
- Services have developed in an organic and ad-hoc way resulting in un-coordinated points of delivery, inequitable access, limited integration with primary care and confusion for patients due to inconsistent service provision.
- Improving access to general practice and other primary care services is a priority for the NHS. There is a national policy drive to provide accessible Primary Care services 8am to 8pm, seven days a week.
- 50% of patients attending General Practice have conditions that do not need a GP and could be appropriately treated by less qualified staff; a further 30% of patients have conditions that other clinical staff could treat.
- 40% of Emergency Department and 70% Minor Injury Unit (MIU) attendances could be seen in primary care.
- The MIUs currently see c.20-25 patients/day (<2/hr/day) between 08:00-22:00. They are financially unsustainable in the longer term in their current form.
Urgent Access to Care – national reasons to change

Locally our plans have been focused on primary care, Chesterfield Royal Hospital and minor injuries services. This section puts that in the context of the national strategy for urgent and emergency care, which sets out principles, standards and targets for service change which will inform and extend local plans.

Transforming urgent and emergency care services in England

The urgent and emergency care review (Professor Sir Bruce Keogh, 2013) proposes a fundamental shift in the way urgent and emergency care services are provided to all ages, improving out-of-hospital services so that we deliver more care closer to home and reduce hospital attendances and admissions. The vision of the review is simple:

For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.

For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

Delivered by five key changes:

1. Providing better support for people and their families to self-care or care for their dependants.
2. Helping people who need urgent care to get the right advice in the right place, first time.
3. Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
4. Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
5. Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

Strategic Networks

Urgent and Emergency Care Networks will be based on the geographies required to give strategic oversight of urgent and emergency care on a regional footprint, ensuring that patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise (red section of the diagram), whilst also assuring that individuals can have their urgent care needs met locally by services as close to home as possible (blue section of the diagram).
Urgent Access to Care – description of service changes explored locally

Within that national context, three local priorities have been focussed on to date: i) the Emergency Centre at Chesterfield Royal ii) Minor Injury Services iii) Primary Care.

Current model:

Emergency Centre at Chesterfield Royal

- ‘Front door’ comprises of two components:
  - Emergency Department (ED) seeing ‘Majors’ and ‘Minors’
  - Primary Care Streaming Service
- These two components are supported by a range of emergency services ‘sat behind’ ED.

Minor Injury Services

- Two local Minor Injury Units (MIUs) provided from Whitworth Hospital in Matlock and Buxton Hospital in Buxton. Both MIU services are underutilised; seeing on average <2 patients per hour compared to a capacity of 4 per hour
- The majority of activity in these units is injury related rather than illness (diagnostics provided on site), however a significant proportion of this could be treated in primary care or through patient self-caring; they are therefore in essence providing additional primary care capacity
- Each of the MIUs very much services the local population around where they are based in Matlock and Buxton
- Chesterfield Royal Hospital also provides minor injury services, particularly to the residents of Chesterfield. 23% of all minor injury activity is delivered by units outside of North Derbyshire

Primary Care

- ‘Core’ primary care is delivered by 52 practices across North Derbyshire during the hours of 08:00-18.30 Monday to Friday. Some practices deliver extended hours, however this is specifically for routine non-urgent appointments and is not provided by all practices.
- Between 18:30-08:00 Monday to Friday and at weekends and Bank Holidays when local GP surgeries are generally closed, as well as at EDs and MIUs people can access face to face urgent primary care at out of hours primary care centres via NHS 111 (following triage).

Service changes explored:

Emergency Centre at Chesterfield Royal

1. A ‘co-located’ urgent care centre with the Emergency Department to enable patients with less serious conditions to be streamed to more appropriate services that are fully integrated
2. A ‘co-located’ urgent care centre with ED together with greater integration between the Emergency Department and the wider emergency services in the hospital, specifically the Acute Frailty Service and Paediatrics

Minor Injury Services

1. Provided at Chesterfield Royal Hospital only
2. Provided at Chesterfield Royal Hospital and Buxton
3. Provided at Chesterfield Royal Hospital, Buxton and Whitworth
4. Provided at Chesterfield Royal Hospital, Buxton, Whitworth, Clay Cross, Bolsover and South Sheffield

Primary Care

1. ‘Extended’ primary care hours 18:30-20:00 Monday to Friday and 08:00-13:00 Saturday to Sunday – delivered by a General Practitioner (GP)
2. ‘Extended’ primary care hours 18:30-20:00 Monday to Friday and 08:00-13:00 Saturday to Sunday – delivered by an Advanced Nurse Practitioner
Urgent Access to Care – Emergency Centre at Chesterfield Royal Hospital (CRH)

The ED at CRH delivers ‘major’, ‘minor’ and primary care services. However the service is not as efficient or as integrated as it could be. Initial work focused on co-locating an urgent care centre, but this would increase costs by £600k without addressing all the challenges. More work is required quickly to develop a model which will co-locate an UCC and integrate the wider emergency services within CRH.

Current delivery model at CRH

- Initial or ‘front-door’ face to face urgent and emergency care delivered at Chesterfield Royal Hospital (CRH) is made up of the Emergency Department (ED), which delivers ‘minor’ injury and illness care as well as ‘major’ care and the Primary Care Streaming Service, which manages many of the ‘minors’ that present between 6pm-10pm Monday to Friday and 9am to 10pm on weekends and Bank Holidays. 40% of patients attending ED are ‘minors’ or require a primary care service
- In addition there are a number of other key components of the urgent and emergency care response delivered from CRH that ‘sit behind’ the ED. These include: an Adult Clinical Decision Unit; an Acute Frailty Unit and front door assessment service; the Paediatric Ward; Paediatric Rapid Assessment Access Clinics; Medical Ambulatory Care

<table>
<thead>
<tr>
<th>ED Majors</th>
<th>ED Minors</th>
<th>GP Streaming</th>
<th>All contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacts</td>
<td>44,400</td>
<td>22,700</td>
<td>6,900</td>
</tr>
<tr>
<td>Cost (£m)*</td>
<td>£5.9m</td>
<td>£0.5m</td>
<td>£6.4m</td>
</tr>
</tbody>
</table>

Key challenges to overcome

- Sustained delivery of ‘4 hr A&E’ target without unnecessary admissions.
- Delivery of emerging national Urgent Care standards, particularly the co-location of an Urgent Care Centre with an Emergency Department
- Ensuring patients attending ED who need a primary care service receive that primary care service and that the specialist staff focus on the ‘major’ patients.
- Reduce avoidable non-elective admissions and short lengths of stay, especially for children and the frail elderly.
- Ensuring a clinically and financially sustainable ED at CRH that in the long term is a key component of the operational urgent and emergency care network.

Alternative models:

Option 1: co-located Urgent Care Centre (UCC) with ED at CRH

- Work on alternative care models to address the challenges faced at CRH initially focused on establishing a co-located Urgent Care Centre with the ED to enable patients with less serious conditions to be streamed to a service more appropriate to their needs. The UCC would be open every day from 8am to 12pm and staffed by Advanced Nurse Practitioners (ANPs) from 8am to 12pm with additional GP input from 6pm to 12pm weekdays and during the day on weekends and Bank holidays
- This option would offer 40% of patients a more appropriate service and enable more focused attention on the ‘major’ cases. However it would cost an additional c.£600k over current ED cost (pay costs only) and would not reduce avoidable non-elective admissions through ED

Option 2: enhanced co-located Urgent Care Centre

- An alternative model is being explored which provides greater integration between ED and the wider emergency services that sit behind ED
- The co-location of a UCC with ED on the CRH site would still be a core component of this model but two further components of care would be included within the ED to reduce avoidable admissions through the Department: an enhanced Acute Frailty Service providing 7-day multi-disciplinary team assessment &; a Paediatric Assessment Unit

The system needs to do more work to understand how the ED at CRH can be fully integrated with the wider emergency services that sit behind it to deliver better patient care and ensure a financially viable future for the service in the long term. This needs to be done in the context of a whole system urgent and emergency care strategy.
Urgent Access to Care – Minor Injury Services

Minor Injuries are currently treated in General Practice, hospital Emergency Departments (EDs) and local Minor Injury Units (MIUs); many of those seen could be treated in primary care. Existing MIUs are not cost-effective but currently there are no reasonable alternatives that would allow for acceptable travel times for some patients in the west of North Derbyshire. Further work is needed to develop an integrated urgent care offer built around primary care.

Descriptions: minor injury and minor illness

Minor injuries include less serious wounds, lacerations, burns, uncomplicated fractures and ligament or muscles injuries (75% of activity). Minor illnesses include local infections, eye problems and skin problems (25% of activity).

Current model

Services for people with minor injuries are currently provided in three ways:

- All General Practices in the North Derbyshire UoP provide a minor injury service from 8am-6.30pm Monday to Friday (without X-ray/diagnostics)
- Emergency Departments at Chesterfield Royal Hospital and other cross border acute hospitals provide a minor injury service 24/7
- Minor Injuries Units (MIUs) at Buxton and Whitworth provide an ANP led service from 08:00-22:00 seven days a week and a ‘Walk-in’ Centre in New Mills delivers an Advanced Nurse Practitioner service (evenings and weekends)

Current activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Current Activity</th>
<th>Needs Specialist Urgent Care</th>
<th>Could be seen in Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>Not recorded</td>
<td>Not recorded</td>
<td>Not recorded</td>
</tr>
<tr>
<td>CRH ED</td>
<td>29,600</td>
<td>9,768</td>
<td>19,832</td>
</tr>
<tr>
<td>MIU Buxton</td>
<td>8,650</td>
<td>2,855</td>
<td>5,796</td>
</tr>
<tr>
<td>MIU Whitworth</td>
<td>8,270</td>
<td>2,729</td>
<td>5,541</td>
</tr>
<tr>
<td>Out of Area</td>
<td>12,560</td>
<td>4,145</td>
<td>8,415</td>
</tr>
<tr>
<td>Total</td>
<td>59,080</td>
<td>19,496</td>
<td>39,584</td>
</tr>
</tbody>
</table>

- The MIUs at Buxton and Whitworth are open 14 hours a day and see approximately 25 patients/day (<2/hour). About two thirds of those patients could have been managed by their GP or by ‘self-caring’

Key challenges

- How can we provide a service that is: cost effective, meets need, keeps travelling time to an acceptable level, is simple for patients to understand and navigate and meets the Keogh standards
- The MIUs at Buxton and Whitworth currently see low levels of activity, 70% of which could clinically be seen by General Practice or self-cared. They are not cost effective, but do offer minor injury care within a reasonable travelling distance for residents of in the west of North Derbyshire

Options considered

<table>
<thead>
<tr>
<th>Option</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED at CRH &amp; ‘out of area’ only</td>
<td>C30% of people in the west of North Derbyshire would have to travel &gt; 20 minutes</td>
</tr>
<tr>
<td>ED at CRH + MIU at Buxton</td>
<td>Most people in the Dales would have to travel &gt; 20 minutes</td>
</tr>
<tr>
<td>CRH; Buxton; Whitworth</td>
<td>Increase costs by £800k to service 2400 minor injuries: c. £333/ event</td>
</tr>
<tr>
<td>ED in all communities</td>
<td>Very costly and highly under utilised</td>
</tr>
</tbody>
</table>

In addition to ED / UCC provision at CRH, servicing Chesterfield and surrounding areas, there is a need to also provide access for minor injury services in the west of North Derbyshire.

However the current MIU services are not cost effective or equitably distributed and predominantly treat patients who could be seen in GP practices.

It is clear that a more integrated urgent care offer built around primary care is required to make more efficient use of resources; this needs to consider how it better services minor injuries.
Urgent Access to Care – General Medical Practice

GP practices are the biggest providers of urgent care for North Derbyshire. Demand for their service is rising whilst the GP workforce is decreasing with patients concerned about access and GPs concerned about capacity. Adding extra capacity in the evening and weekends seems the most achievable solution and is in line with national policy but no model has yet been agreed to do this across the North Derbyshire UoP. Local GP communities are being asked to develop plans to extend and integrate urgent care.

Current delivery model

- C60% of all urgent care is delivered by the 52 GP practices between 08:00-18:30 Monday to Friday. Some practices deliver extended hours for routine non-urgent appointments.
- Between 18:30-08:00 when local GP surgeries are generally closed people can access face to face urgent primary care in three ways: at the ED department of an acute hospital; at a Minor Injuries Unit – there are two located within North Derbyshire at Buxton and Whitworth; at an Out of Hours (OOH) primary care centre, primarily at the Ashgate Manor site, Chesterfield.
- The NHS111 service triages OOH patients and provides ‘hear and treat’ care.

<table>
<thead>
<tr>
<th>Total Activity</th>
<th>All Activity</th>
<th>Extended hours*</th>
<th>% Total Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department [Minors/primary care]</td>
<td>29,546</td>
<td>5,970</td>
<td>21.0%</td>
</tr>
<tr>
<td>Buxton/Whitworth MIU [suitable for Primary Care]</td>
<td>11,336</td>
<td>2,014</td>
<td>17.5%</td>
</tr>
<tr>
<td>Out of Hours Primary Care [all activity types]</td>
<td>59,660</td>
<td>21,781</td>
<td>36.5%</td>
</tr>
</tbody>
</table>

* Extended hours = 18:30-20:00 M-F and 08:00-13:00 Sat. and Sun.

Key challenges to overcome

- Improving access to general practice and other primary care services is a priority for the NHS. There is a national policy drive to provide accessible Primary Care services 8am to 8pm, and provide services 7 days a week.
- Patient survey results and local consultation suggest the public wish to see access to primary care services improved. This concern is mirrored by practices, who are concerned about their ability to sustain current service.
- Demand for a GP delivered service is rising and the GP workforce is decreasing. However evidence suggests 50% of patients attending General Practice could be appropriately treated by more junior/less qualified staff using evidence based standard processes. A further 30% of patients have conditions that do not require GP input that other clinical staff could diagnose and treat.
- Other providers are reporting increasing demand for services, particularly in the early evening and at weekends.

Improving access : GP / Advanced Nurse Practioner (ANP) models

- Work with General Practice to improve access to primary care is focussed in two areas; i) during ‘core’ hours of 08:00-18:30 and ii) during the ‘extended hours’ period of 18:30-20:00 and Saturday and Sunday morning. Increasing access during the extended hours period was thought to be more achievable in the short term, and work initially focussed on developing a GP led service.
- A single service would be provided within each community that would offer telephone triage and bookable face to face urgent appointments. However discussion with General Practice suggests that there is little support for this model and no assurance that it could be provided consistently across North Derbyshire at this time making it unfeasible as a replacement service and unlikely as an additional service.
- The second option considered was the same model but staffed by ANPs. This would be less expensive than the GP led model but able to care for the majority of patients. However some concern was raised about the value of this model in terms of overall health benefit, the governance arrangements, and the difficulty of recruiting ANPs to staff it.

Within the ND UoP there is currently no agreed model of care for adding additional capacity and extending GP opening into the evenings and weekends. However GPs within communities are being asked to develop their own plans to offer improved and extended access. Initial thinking is emerging on supporting those most at risk of admission out of hours as part of a multi disciplinary team.

Nationally there is a target to offer extended access by 2020, and to recruit a further 5000 GPs. Further guidance on this is awaited.
Urgent Access to Care – Summary

Why have we been looking at Urgent Access to Care provision?
• Locally patients report difficulties accessing General Practice and the desire for a more simple and consistent urgent care system; nationally the Keogh review supports this.
• 40% of those attending the Emergency Department (ED) at Chesterfield Royal Hospital could be seen in primary care, sustained delivery of the ED wait target is a challenge and a significant number of admissions could be avoided if alternative services existed.
• The local Minor Injury Units are underutilised, the majority of patients seen have primary care needs, and they contribute to inequitable access across North Derbyshire.

Areas where service change have been explored
• Emergency Centre at Chesterfield Royal
• Minor Injury Services
• General Medical Practice (in hours and OOH)

Where thinking has got to
Emergency Centre at Chesterfield Royal
• Analysis suggests that although the introduction of a co-located urgent care centre at CRH will bring some benefits to the way patients are managed and the care provided, the cost-benefit of implementing this change alone is not sufficient and an alternative approach is required.
• The system needs to do more work to understand how the ED at CRH can be fully integrated with the wider emergency services that sit behind it to deliver better patient care and ensure a financially viable future for the service in the long term. This needs to be done in the context of a whole system urgent and emergency care strategy.

Minor Injury Units
• Offering services dedicated to only servicing minor injuries would be an expensive and inefficient use of resources.
• In addition to ED / UCC provision at CRH servicing Chesterfield and surrounding areas, there is a need to also provide access for minor injury services in the west of North Derbyshire.
• Because existing MIUs (and ED/UCC) also provide additional walk-in access to primary care, communities not locally serviced by such, receive an inequitable service.
• It is clear that a more integrated urgent care offer built around primary care is required to make more efficient use of resources; this needs to consider how it better services minor injuries. This requires much greater engagement and joint working with Primary Care to develop.

General Medical Practice
• Longer term, greater integration between local GP Practices and between primary care and other providers of urgent care, not just in the period 18:30 to 20:00 but throughout the day, is believed to be the right direction of travel; however this is going to take time.
• CCGs need to lead work with networks of GP practices, organised within local communities, to develop plans to extend access in a way that is sustainable, brings health benefit and is in line with national planning guidance (December 2015) to deliver by 2020. This needs to be locally developed and provide a consistent and equitable service. It could include the use of ANPs and a wider multi-disciplinary team.
**Urgent Access to Care – next steps**

*Local plans to change should be placed within the context of existing networks and the wider national strategy and it’s ‘route map’ aimed at transforming urgent and emergency care. This section sets out the route map in more detail.*

### Organising to deliver change

Many of the services that provide care urgently span a wide area (e.g. ambulance services and emergency centres at acute hospitals). The country is organised into networks to ensure that we co-ordinate and plan services effectively. North Derbyshire is part of two urgent care networks:

- **Urgent and Emergency Care Network (UECN):** this is a strategic network which spans Derbyshire; Nottinghamshire; Leicestershire; Lincolnshire and South Yorkshire
- **North Derbyshire System Resilience Group:** this is an operational network which spans North Derbyshire and links with other local networks

### Incorporating and delivering national plans

The Keogh Review has led to a suite of guidance documents and tools to support commissioners and providers to deliver the national programme. These include good practice guides on delivering urgent and emergency care for people who need specialist hospital services (‘Safer, Faster, Better’ (2015)), commissioning standards for designing the NHS urgent care ‘front door’, focusing on NHS 111, access to primary care and the development of clinical hubs (Commissioning Standards Integrated Urgent Care, 2015); and guidance on the accepted standard for acute facilities and for urgent care centres and emergency centres (2016).

The NHS England Urgent and Emergency Care Route Map sets out the key national and local deliverables and timescales for implementation of the Urgent and Emergency Care Review under nine main sections. It provides priorities for the wider system and the framework for our local development plans, taking into account national priorities, models of care and commissioning guidelines.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Architecture</td>
<td>Establish networks; identify metrics; develop new payment system; enhanced summary care record; develop workforce</td>
<td>2015-2018</td>
</tr>
<tr>
<td>Accessing the UEC system</td>
<td>Make accessing the system more consistent: including via NHS111 and OOH; establish clinical hubs; improved ambulance triage</td>
<td>2015-2016</td>
</tr>
<tr>
<td>UEC centres</td>
<td>Ensure Urgent Care Centres provide a consistent service;</td>
<td>2016-2020</td>
</tr>
<tr>
<td>Paramedic at home</td>
<td>Support more patients to be dealt with at home appropriately by paramedics; and more appropriate 999 responses</td>
<td>2016-2017</td>
</tr>
<tr>
<td>Emergency Centres and Specialist Services</td>
<td>Ensure hospitals provide 7 day services across 10 specialties; improve discharge from hospital; ensure patients are treated in the right networked facilities</td>
<td>2015-2017</td>
</tr>
<tr>
<td>Mental Health Crisis</td>
<td>Standards crisis waiting times 24/7 and assessment standards</td>
<td>2016-2018</td>
</tr>
<tr>
<td>Supporting self care</td>
<td>Provide personal care plans; support self management; personalise health budgets</td>
<td>2015-2017</td>
</tr>
<tr>
<td>Independent care sector</td>
<td>Clarify local commissioning practice; make better use of care homes</td>
<td>2015-2016</td>
</tr>
<tr>
<td>Primary care</td>
<td>Improve access to primary care at weekends and evening; increase pharmacy role</td>
<td>2016-2020</td>
</tr>
</tbody>
</table>
Urgent Access to Care – next steps
This section sets out how we intend to use the existing frameworks, the wider system, and new ideas to deliver both our local priorities and the wider urgent and emergency care agenda.

Embedding 21C urgent care work within the wider urgent care network
The scope for urgent access to care has so far focused on the CRH Emergency Department & GP Streaming Service; Out of hours face to face primary care; Minor Injury Units; Walk-in Centre; Extended access to Primary Care.

As described, the thinking on these has advanced and they now need to be placed within the wider urgent care strategy. This is particularly important as the the NHS UEC review; including the development of national planning priorities and release of commissioning guidelines has gathered pace since July 2015.

There are key elements of the local work that could benefit from regional and national developments, for example the development of a different kind of paramedic service could support minor injuries provision in the west.

The proposal therefore is to establish the urgent care work under the aegis of the System Resilience Group. The SRG will take responsibility for ensuring that the local priorities are linked into regional and national work, and that they are given priority and a clear and realistic timescale within a comprehensive and strategic urgent care approach for the North Derbyshire Unit of Planning.

To do so these priorities will need effective support; the remit and membership of the group leading this work will need to be broadened to encompass primary and community care.

Next steps
The System Resilience Group are tasked with establishing the work group to action the key pieces of work outlined above. The draft proposed timescale developed by the existing urgent care work group is as follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>Key tasks</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH UCC</td>
<td>• Agree ‘enhanced’ UCC service spec.</td>
<td>April 16</td>
</tr>
<tr>
<td></td>
<td>• Plan and mobilise new UCC model</td>
<td>April 17</td>
</tr>
<tr>
<td></td>
<td>• Develop full UC ‘village’ case</td>
<td>Dec.16</td>
</tr>
<tr>
<td></td>
<td>• Implement full UCV</td>
<td>Dec.18</td>
</tr>
<tr>
<td>MI services</td>
<td>• Develop options &amp; new business case</td>
<td>Dec.16</td>
</tr>
<tr>
<td></td>
<td>• Consult on options</td>
<td>March 17</td>
</tr>
<tr>
<td></td>
<td>• Planning and implementation</td>
<td>March 18</td>
</tr>
<tr>
<td>Primary Care</td>
<td>• Develop pilot sites for extended access</td>
<td>April 16</td>
</tr>
<tr>
<td></td>
<td>• Evaluate pilot work</td>
<td>April 17</td>
</tr>
<tr>
<td></td>
<td>• Roll out to provide 100% cover</td>
<td>2017-20</td>
</tr>
<tr>
<td>NHS 111 re-procured</td>
<td>• Contract sign off</td>
<td>April 16</td>
</tr>
<tr>
<td></td>
<td>• Mobilisation and launch</td>
<td>October 16</td>
</tr>
<tr>
<td>OOH procurement and ‘go live’</td>
<td>• New spec developed and signed off</td>
<td>July 16</td>
</tr>
<tr>
<td></td>
<td>• Contract sign off</td>
<td>Nov.16</td>
</tr>
<tr>
<td></td>
<td>• Mobilisation and launch</td>
<td>June 17</td>
</tr>
</tbody>
</table>

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
Services for people with a Learning Disability

This sub-section provides an overview of the proposed changes which are being developed in line with the National Policy ‘Building the Right Support’.

This summary contains:
- Scope of services impacted by the proposals
- Summary of the case for change
- Overview of the proposed changes to Short Break (respite) provision
- Overview of the proposed changes to provide a Unified Community Learning Disability service
- Outline implementation plan
- Summary of the benefits and implications
Services for people with a Learning Disability - scope

There is opportunity to better meet the needs of people with a learning disability, in particular those with the most complex needs and multiple disabilities. This requires community based services across health & social care to be better integrated.

Context – case for change

Every person with a learning disability in Derbyshire is entitled to the same opportunity to lead their life, as valued and respected members of their community, in the same way as everyone else.

Specialist health and social care services need to be organised to provide integrated personalised and self-directed care and support. This care and support must enable everyone to secure their rights, independence, choice and inclusion. Specialist services must give particular priority to those people most at risk of receiving their care and support in high cost institutional care.

Currently services are not consistently meeting these aims: they are fragmented, inequitable, overly reliant on bed based care and offer poor value for money.

National policy is directing the necessary changes to better meet the aims; most recently, ‘Building the right support: a national implementation plan to develop community services and close inpatient facilities’ (October 2015) set out that:

i) Local councils and NHS bodies will join together to deliver better and more coordinated services.

ii) Budgets will be shared between the NHS and local councils to ensure the right care is provided in the right place.

iii) National guidelines will set out what support people and families can expect, wherever they live

In Derbyshire, there is particular focus on how we can improve the way we provide care and support for those people with complex needs and multiple disabilities, whilst continuing to reduce the number of people with a learning disability who need to rely on specialist health and social care services to maintain their health and wellbeing.

Comparatively expenditure per person is significantly higher in North Derbyshire and Derbyshire than elsewhere in England.

Scope of services

In North Derbyshire there are 2041 people with a moderate or severe learning disability known to Adult Social Care. The number of people with significant and complex needs has been increasing and there are 703 people recorded as having complex needs registered with a GP practice across the north of the county.

Derbyshire County Council and Derbyshire NHS Clinical Commissioning Groups gross spending on specialist health and social care services for people with a learning disability is £100m. About £54.5m of this is spent on people who are living in the north of the county.
Services for people with a Learning Disability – why change

The events at Winterbourne View, the Confidential Inquiry into Premature Deaths of people with a Learning Disability and the more recent National Plan ‘Building The Right Support’ highlight the importance of action to develop community services for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition and to improve the quality and effectiveness of health and social care. This will require sufficient skilled support to people throughout or at various times in their lives.

Improving the quality of care:

- Specialist Learning Disability health and social care community team interventions, crisis and intensive outreach and inpatient services including bed based short breaks (respite) vary across Derbyshire and it is the intention of commissioners to address the imbalance and inequity of access to health care responses and potential for discrepancies in outcomes.
- This rebalance will be set in the context of appropriate access to mainstream mental health, primary and secondary care services and a flexible range of community social care provision and access to personal budgets and personal health budgets.
- Research evidence suggests that when people with mental health problems and/or challenging behaviour receive support in the community as opposed to hospital there are better outcomes in terms of repeated admissions to hospital, mental health, carer distress and patient and family satisfaction with the care that they receive (Marshall & Lockwood, 1998; Joy, Adams & Rice, 2004).

Improving the sustainability of the workforce:

- Redirection of resources and priorities will be required to enable the current workforce to change and in some instances increase to address the most complex needs of people with a learning disability.
- Services are currently delivered within local identified communities; this needs to be further developed so that integrated health and social care specialist support for people with a learning disability is aligned to the community hub vision. This will require a collaborative care model avoiding substantial relocation of staff.
- Highly skilled and experienced health and social care staff working jointly to deliver proactive and reactive strategies for support in the community. This will include comprehensive joint assessments, enhanced case management, shared accountability for care and support, joint care planning, inter professional networking
- The desired outcomes for people with a learning disability require joint concerted efforts across all sectors who have an impact upon a persons life to take a shared responsibility to strengthen and improve the skills of the workforce.

Improving service effectiveness and efficiency:

- The benefits to individual people, their carers and the wider community from people with a learning disability being supported to live in their own communities with a higher quality of service provision are significant and should be the driving factor in taking this change forward.
- Building the Right Support published in October 2015 proposes that costs of the new national service model of care will be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results.
- This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support).
Services for people with a Learning Disability – proposed changes to Short Break (respite) provision

The proposal is to create a more personalised, efficient and effective offer for adult short breaks (respite) by developing a mix of bed based and other alternatives that will meet a range of individual need and aspirations, through personal budgets and self directed support.

Most of the current bed based accommodation has largely remained unchanged for years and is reportedly underutilised.

Building-based short break (respite) services are inflexible, expensive to maintain as a model of care and this questions the long-term viability of this model.

In response to NHSE policy and the NHSE service model no one should be in a specialist Learning Disability inpatient bed unless they are admitted for assessment and treatment.

Currently DCHS provide 25 short break inpatient care beds across 5 sites. One of the short break (respite) units is based on a hospital site. These NHS resources are inpatient facilities that are not commissioned to provide assessment and treatment, but have been commissioned to provide short breaks. This NHS service model is therefore outdated and requires redesign to ensure it is fit for the future.

There is an under utilisation of the available beds, and disproportionate costs which do not correlate to individual need.

The emphasis of the future for Short Breaks (respite) is on the availability of flexible, individualised short breaks.

There will be continued commitment to ensure short break (respite) is available from alternative options to those provided by the NHS to support individuals and their families to continue to provide support and deliver personal outcomes.

In line with NHS England policy there will be a transfer of arrangements from the current position.

The model will reflect the changing priorities, the change in the level of demand and alternative provider market options.

A ‘menu’ of short breaks options should be available and people should experience:

- Choices about how short breaks are taken by offering a variety of activities and support options, not just bed-based short-breaks (respite)
- Responsiveness so people have better support at times of crisis
- Accessible information and excellent communication
- Reduced reliance on bed-based short breaks (respite) so people can have a wider range of options and alternatives to traditional models of short breaks
- Access to the Shared Lives Scheme
- Offer of a personal budget for people who want to make alternative choices or their own arrangements
- And consequently, improved outcomes for their health and well being.
Services for people with a Learning Disability – proposed changes to provide a Unified Community Learning Disability model

The proposal is to develop new approaches to care and support pathways that will make the best use of collaboration, joint working and existing networks of care and support.

1. From existing models of community teams and acute assessment and treatment inpatient beds

Current specialist health care services are concentrated around core accommodation units, a purpose built hospital at Ash Green (Chesterfield) and three geographical based community learning disability teams.

The hospital includes outpatient facilities for psychiatry consultant-led and sensory and therapy services.

A small number of Individuals with a learning disability from north.

All social work inputs are currently provided on a generic team basis.

Derbyshire are also currently receiving rehabilitation and treatment in private independent hospitals, most of which are inside the border of Derbyshire. There are also a large number of people with a learning disability receiving their care in institutional settings through continuing care and social community care arrangements, in and out of the area.

2. Towards improved integrated community responses

Access to countywide specialist accommodation to provide intensive assessment and treatment where this is required.

Alternative short term accommodation will be used in times of potential crisis for short periods to provide a setting for assessment by multi-disciplinary health and social care integrated teams where this cannot be carried out in the individual’s home.

Continued development and enhancement of community responses as an alternative to bed based services. This will include the ability to provide a 24/7 hands on intensive response to prevent or manage crisis.

A robust health and social care community infrastructure that takes a broad view on addressing health and well-being and considers the range of factors associated with poorer health and other risks associated with social exclusion.

3. To personalised care and support in the community

The Unified community health and social care response will carry out five core functions:

1. Support positive access to and responses from mainstream services, to improve the experience and outcomes and reducing known health inequalities for people with a learning disability.

2. Enable others to provide effective person-centred support to people with a learning disability. This includes targeted assessment and formulation and providing training.

3. Deliver direct social and specialist clinical therapeutic support such as assessment, intervention, and formulation, positive behavioural support and psychological and therapeutic support.

4. Respond positively, rapidly and effectively to crises, with the ability to provide 24x7 support.

5. Quality assurance and strategic service development to support commissioners in service development, the commissioning of individual support packages and quality monitoring.
Services for people with a Learning Disability – outline implementation plan
Subject to the outcome of Consultation, the proposed implementation plan consists of an 18 month programme – that is currently planned to commence 1st June 2016 - through to 1st March 2018.
The delivery will be significantly influenced by the requirement for robust implementation plans to respond to the National Policy ‘Building the Right Support’ by April 2016.

Theme 1 - Short Breaks (respite)
Part 1 - A rolling programme of personal reviews conducted over a period of 3 months per each of the five NHS core units (timescale 01/06/16 -31/08/17)
Part 2- Upon completion of Part 1 for each core unit; to commence a rolling 6 month phased transition from NHS inpatient short breaks (respite) to implementation of alternative short breaks (respite) based on individual outcomes and alternative choices from personal reviews and offer of personal budgets (01/09/16 -28/02/18)

Note – A Short Break (respite) work programme is required to:
1. Establish alternative short break menu of options.
2. Proceed to market management, signalling to providers and the holiday and leisure market the need for bed based and alternatives to bed based solutions for short breaks.
3. Complete a desk top analysis across all 5 core units and establish indicative Personal budgets and process for offering a PHB, to prepare for effective person centred engagement with individuals and their families.
4. Refresh the strategic commissioning review of short break options across health and social care and the options appraisal from 2012 and reaffirm recommendations.

Theme 2 - Unified Community Model
This delivery combines four key components:
Part 1 – Intensive Support Service
• Recruitment to develop a 7 day multi-disciplinary Intensive Support Team. Aspiration is to commence from 01/06/16
• Evaluate at 6 months (Dec 16) and 12 months (June 17)
Part 2 – In-Patient Assessment and Treatment
• To continue with access to 6 inpatient beds on Hillside for a period of six months post start date of the 7 day intensive support service.
• Review (Dec 2016) the intelligence gathered from monitoring in-patient hospital bed usage alongside the developing service model for Intensive support and determine the local requirements for learning disability assessment and treatment in-patient beds for the foreseeable future.
• From June 2016 – November 2016 conduct a joint rationalisation of all available community bed based accommodation
• To adjust the number of Learning Disability assessment and treatment in-patient beds required and implement adjustments from January 2017.
Part 3 – Community LD Teams
• To strengthen the professional therapy composition of the current community Learning Disability teams (CLDTs) with targeted recruitment that will deliver the skill mix and expertise required for the future community model.
Part 4 – Workforce and Provider Development
• Provide a management of change programme for existing DCHS and ASC staff working across in-patient areas, community teams and residential teams, – in line with requirements of the National Model and Vision and Aims of the 21c Learning Disability workstream. (Feb - June 2016).
• Commissioners to develop a market development programme to run concurrently to establish partnerships and develop the joined up collaboration required across all care/support provider sectors in Derbyshire to effect the cultural shift required to successfully achieve the new model and sustain skills and expertise of the varied workforce.
Services for people with a Learning Disability – Benefits Summary

Services will be available in the community, be highly personalised and based on life long person centred planning and approaches. People with a learning disability able to remain in their local community setting, with additional intensive support, with the human and financial benefits associated.

Quality benefits

- Specialist learning disability health and social care services that support mainstream practice and directly serve those with the most complex needs.
- Acute admission avoidance and people staying close to home.
- People with a learning disability able to remain in their community setting, with additional intensive support, with the human and financial benefits associated.
- Improved patient and carer satisfaction through improved access.
- Patient/carer needs met in a more timely fashion in their normal place of residence.
- Service capacity that directs people away from traditional/institutional responses to crisis and, wherever possible, supports people in their everyday surroundings.
- Support to people and families when needed through swift access to the services of specialist professionals including medical, nursing and allied health professionals.
- Joint planning and the development of integrated care pathways that promote individualised services that are closer to home.

Financial benefits

- The reduction in acute assessment and treatment beds will pave the way for transfer of resources to support the development of a community response and allow for new and emerging pathways signalled strongly by national policy.
- From current available information it is assumed there will be efficiency savings from no longer commissioning and providing NHS short break (respite) beds and instead offering personal budgets.
- By offering a fair and equitable alternative personal offer to people using short breaks (respite) would free up resources locked into buildings and inflexible care models. Reinvestment of resources will contribute to the costs of developing a robust 7 day unified community assessment and treatment model.

Workforce implications

- A redirection of resources and priorities will be required to enable the current establishment of the workforce to change and in some instances increase to address the most complex needs of people with a learning disability.
- In line with a management of workforce and organisational change programme, we will train and support existing staff teams to deliver new care and support pathways; working patterns of the workforce may also need to change to meet desired outcomes of the emerging pathways/models of care.
- One of the key aims will be to redeploy existing staff wherever possible.
- Transitional costs including training and any other workforce change costs will be defined as part of the management of change programme.
- Commissioner and contracting approaches to develop and sustain the skills and expertise of the Derbyshire workforce, working collaboratively to take shared responsibility and accountability for people with a learning disability.

Other community service implications

- Ensuring that the ‘voice’ of people and families is heard and there is appropriate representation and co-production (including independent advocacy).
- Coordinating this in a stepped approach will enable a safe and considered approach to service redesign and allow commissioners and providers to gain further intelligence about real demand and potential gaps for the future transformation.
Services for people with a Learning Disability – Proposal Summary

So, in summary what is being proposed (subject to consultation)...

1) The core change in North Derbyshire is to develop a unified, robust community service incorporating the current community learning disability teams, acute and primary liaison services, access to specialist accommodation for assessment and treatment as well as facilities to provide temporary alternative care when needed, with an enhanced Intensive Support Team. Moreover, these services will be integrated (Joined Up) with the broader community based services and adult social care.

2) In line with NHS England policy there will be a transfer of arrangements away from the current bed based position. Whilst there will be a continued offer of short break (respite) options that achieve personalised outcomes, there will be a move from an NHS bed based approach to a range of alternatives that include building based accommodation. It is expected that these changes will offer significantly better value for money (savings) – which will enable re-investment into the development of the robust community services outlined above.

3) The intention is to develop a pooled budget during 2016, utilising the Health Act Flexibilities provided though a Section 75 agreement.
Other services (impacted by the proposed changes)

The sub-section contains:
- Scope of services impacted by the proposals
- Summary of the case for change
- Description of the evaluation process
- Site impacts of the proposed service changes
- Summary of the next steps

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
Other services - scope
The proposals related to the other elements of the business case have a significant impact on the configuration of services within each of the communities.
This presents the need and opportunity to further consider how other community services, currently delivered from the sites affected, can be delivered most effectively in the future.

Context – case for change
As described previously:

Community hubs will provide and support joined up community based care services; developed with local people to meet their needs.

Hubs will:
• Provide ‘out of hospital’ places from which JoinedUpCare will be delivered.
• Service the needs of children and adults.
• Support the integration and delivery of mental health, physical health and social care – to meet whole needs of people (‘whole person care’).
• Offer urgent, planned and bedded care to complement services provided at home and in hospitals - delivering the right care, in the right setting, by the right people.
• Meet the specific needs of local communities; not one size will fit all.
• Recognise that different communities will start with different services and facilities (including primary care).
• Be delivered from a combination of the most appropriate physical locations to balance access and resilience needs.
• Take account of housing developments and new facilities.
• Consider how technology can support new approaches to care delivery.

The proposals related to the other elements of the business case (specialist OPMH and day unit care, community bedded care and LD) each have an impact on the configuration of services within each of the communities.

Scope
The move to provide more community based services (and less bed based care) presents the need and opportunity to further consider how other community services currently delivered from those sites can be delivered most effectively in the future.

The proposed OPMH changes would result in no specialist OPMH bedded care being delivered from Cavendish and Newholme hospitals and Day Unit services (currently delivered from Walton, Newholme and Bolsover) being delivered instead within people’s homes or in their local communities.

The proposed community bedded care changes would result in community hospital based bedded care no longer being provided from Bolsover, Clay Cross, Newholme and Whitworth.

There are broad range of other services currently being delivered from these community hospital sites including:
• Acute specialist outpatient clinics
• Community nursing and therapy clinics
• Minor surgical procedures
• Diagnostic testing
• Minor Injury Units

In addition, some sites have a co-ordination and team base role.
Other services – option evaluation

Site rationalisation opportunities are being considered taking account of the impact of the proposed changes, services currently delivered from the sites impacted, the state of the site and its potential role within the development of community hubs. Evaluation uses the same criteria used for other elements of the community hubs proposals.

1. People kept at home and independent wherever possible
2. Improved access to care
3. Improved service effectiveness and efficiency

See Appendix for Full Criteria
Other services – site impact overview

*Each of the community hospital sites impacted by the changes have been considered.*

**Sites impacted**
The figure below shows the locations of the community hospitals impacted by the proposed OPMH and community bedded care changes.

**Site profiles**
For each of the sites impacted by the proposed service changes, at appendix is a ‘site profile’ which provides:

- A summary of what the site does and the impact of proposed changes
- A table describing the services delivered from the site
- A table providing an overview of the site from an estates perspective
- A summary of key consideration for future of the site

This information has been used to inform an options evaluation process which has considered the potential site rationalisation.
Other services – scale and nature of the site impact of the proposed changes

As a result of the options analysis, it was determined that sites at Buxton, Cavendish, Whitworth and Walton would need to continue to deliver services which require hospital facilities. Other sites at Bolsover, Clay Cross and Newholme would no longer provide bedded care and so should be the subject of further more detailed consideration.

<table>
<thead>
<tr>
<th>(1) Current services:</th>
<th>Bolsover</th>
<th>Buxton</th>
<th>Cavendish</th>
<th>Clay Cross</th>
<th>Newholme</th>
<th>Walton</th>
<th>Whitworth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community bedded care (beds)</td>
<td>16 (+16)</td>
<td>-</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>OPMH dementia bedded care (beds)</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Minor Injuries Unit</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Clinics – attendances</td>
<td>2,300</td>
<td>13,000</td>
<td>14,500</td>
<td>22,600</td>
<td>12,500</td>
<td>6,000</td>
<td>12,000</td>
</tr>
<tr>
<td>OPMH day unit</td>
<td>1,900</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,600</td>
<td>3,700</td>
<td>-</td>
</tr>
<tr>
<td>Community team base</td>
<td>yes</td>
<td>-</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) Proposed changes:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community bed changes</td>
<td>no beds</td>
<td>-</td>
<td>8 specialist rehab beds</td>
<td>no beds</td>
<td>no beds</td>
<td>-</td>
<td>no beds</td>
</tr>
<tr>
<td>OPMH changes</td>
<td>-</td>
<td>-</td>
<td>no specialist OPMH beds</td>
<td>-</td>
<td>no specialist OPMH beds</td>
<td>32 specialist OPMH beds</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) Remaining services:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Require hospital facilities?</td>
<td>not necessarily</td>
<td>yes (MIU)</td>
<td>yes (rehab beds)</td>
<td>not necessarily</td>
<td>not necessarily</td>
<td>yes (OPMH beds)</td>
<td>yes (MIU)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(4) Next step:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conclusions</td>
<td>further review</td>
<td>no change</td>
<td>no change</td>
<td>further review</td>
<td>further review</td>
<td>no change</td>
<td>no change</td>
</tr>
</tbody>
</table>

Notes:
- It is proposed that 24 specialist rehab beds will also be delivered from the Chesterfield Royal Hospital site.
- Further worked has been agreed to look at all facilities in Buxton.

Overview of services delivered and proposed changes

Taking account of the proposed changes to Specialist OPMH, Dementia Day Units and community bedded care, analysis shows the impact on seven community hospital sites. This is summarised in the table above.

Of the seven sites:
- Sites at Cavendish and Walton would continue to deliver ward based bedded care. As such the hospital facilities are still required and therefore there has been no further consideration of these sites.
- No proposals are yet being made to change the provision of urgent care services including MIU facilities, which require access to hospital facilities (e.g. diagnostics). As such, the hospital facilities are still required and therefore there has been no further consideration of these sites (at this stage).

Conclusions
- Other sites at Bolsover, Clay Cross and Newholme would no longer provide bedded care and so should be the subject of further more detailed consideration.
More detailed consideration – Bolsover after direct impact of proposed changes

Detailed analysis of the patient services delivered from Bolsover site, its usage as a team base and for corporate services plus the situation of the estate (access, maintenance, flexibility, etc.) is summarised in the figures below. The details are contained within the appendix.

Note: clinic attendances at the Bolsover site are significantly lower than at other community hospitals. This is because services are already delivered from other community based locations (Welbeck Road c. 49 sessions per week; Shirebrook Health Centre c.24 sessions per week; Springs Health Centre (Clowne) c.39 sessions per week)

Further details are provided at appendix.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Bolsover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic attendances</td>
<td>2,300</td>
</tr>
<tr>
<td>Day unit attendances</td>
<td>1,900</td>
</tr>
<tr>
<td>Gross Internal Area</td>
<td>4,486</td>
</tr>
<tr>
<td>Current space for clinics</td>
<td>443</td>
</tr>
<tr>
<td>Office space local teams</td>
<td>482</td>
</tr>
<tr>
<td>Office space corporate</td>
<td>282</td>
</tr>
<tr>
<td>Access - public transport</td>
<td>limited</td>
</tr>
<tr>
<td>Access - parking</td>
<td>good</td>
</tr>
<tr>
<td>Flexibility to develop the site</td>
<td>fair</td>
</tr>
<tr>
<td>Cost to maintain the site</td>
<td>low</td>
</tr>
</tbody>
</table>
More detailed consideration – Clay Cross Hospital after direct impact of proposed changes

Detailed analysis of the patient services delivered from Clay Cross site, its usage as a team base and for corporate services plus the situation of the estate (access, maintenance, flexibility, etc.) is summarised in the figures below. The details are contained within the appendix.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Clay Cross</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic attendances</td>
<td>22,600</td>
</tr>
<tr>
<td>Day unit attendances</td>
<td>0</td>
</tr>
<tr>
<td>Gross Internal Area</td>
<td>3,068</td>
</tr>
<tr>
<td>Current space for clinics</td>
<td>820</td>
</tr>
<tr>
<td>Office space local teams</td>
<td>780</td>
</tr>
<tr>
<td>Office space corporate</td>
<td>100</td>
</tr>
<tr>
<td>Access - public transport</td>
<td>limited</td>
</tr>
<tr>
<td>Access - parking</td>
<td>fair</td>
</tr>
<tr>
<td>Flexibility to develop the site</td>
<td>good</td>
</tr>
<tr>
<td>Cost to maintain the site</td>
<td>low</td>
</tr>
</tbody>
</table>
More detailed consideration – Newholme Hospital after direct impact of proposed changes

Detailed analysis of the patient services delivered from Newholme site, its usage as a team base and for corporate services plus the situation of the estate (access, maintenance, flexibility, etc.) is summarised in the figures below. The details are contained within the appendix.
Potential site rationalisation: Summary and conclusions

<table>
<thead>
<tr>
<th>Factor</th>
<th>Bolsover</th>
<th>Clay Cross</th>
<th>Newholme</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic attendances</td>
<td>2,300</td>
<td>22,600</td>
<td>12,500</td>
<td></td>
</tr>
<tr>
<td>Day unit attendances</td>
<td>1,900</td>
<td>0</td>
<td>1,600</td>
<td>&lt;&lt;&lt; potential to deliver more effective care - TBA</td>
</tr>
<tr>
<td>Gross Internal Area</td>
<td>4,486</td>
<td>3,068</td>
<td>5,507</td>
<td>&lt;&lt;&lt; comparative scale of the sites</td>
</tr>
<tr>
<td>Current space for clinics</td>
<td>443</td>
<td>820</td>
<td>975</td>
<td></td>
</tr>
<tr>
<td>Office space local teams</td>
<td>482</td>
<td>780</td>
<td>346</td>
<td>&lt;&lt;&lt; used by teams working with communities</td>
</tr>
<tr>
<td>Office space corporate</td>
<td>282</td>
<td>100</td>
<td>1,340</td>
<td>&lt;&lt;&lt; no need to be delivered from within the community</td>
</tr>
<tr>
<td>Access - public transport</td>
<td>limited</td>
<td>limited</td>
<td>limited</td>
<td></td>
</tr>
<tr>
<td>Access - parking</td>
<td>good</td>
<td>fair</td>
<td>poor</td>
<td></td>
</tr>
<tr>
<td>Flexibility to develop the site</td>
<td>fair</td>
<td>good</td>
<td>poor</td>
<td></td>
</tr>
<tr>
<td>Cost to maintain the site</td>
<td>low</td>
<td>low</td>
<td>high</td>
<td></td>
</tr>
<tr>
<td>Cost of servicing remaining activity (£k)</td>
<td>£748</td>
<td>£400</td>
<td>£610</td>
<td>&lt;&lt;&lt; cost of running the site (excludes cost of providing care)</td>
</tr>
<tr>
<td>Ratio - attends per sq m</td>
<td>5.2</td>
<td>27.6</td>
<td>12.2</td>
<td>&lt;&lt;&lt; rough comparison of how well the clinical space is used</td>
</tr>
<tr>
<td>Ratio - site cost per attendance</td>
<td>£325</td>
<td>£18</td>
<td>£49</td>
<td>&lt;&lt;&lt; comparative cost of clinical use of the site</td>
</tr>
<tr>
<td>Space vacated / unutilised post proposed changes</td>
<td>2,052</td>
<td>702</td>
<td>1,397</td>
<td>&lt;&lt;&lt; space vacated (not assuming any improved utilisation)</td>
</tr>
<tr>
<td>Utilisation of clinical space post proposed changes</td>
<td>26%</td>
<td>54%</td>
<td>50%</td>
<td>&lt;&lt;&lt; not assuming any improved utilisation</td>
</tr>
<tr>
<td>Improved utilisation of clinical space post proposed changes</td>
<td>8%</td>
<td>27%</td>
<td>18%</td>
<td>&lt;&lt;&lt; including improved utilisation</td>
</tr>
<tr>
<td>Propose to deliver care locally from lower cost site(s)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>&lt;&lt;&lt; work to vacate sites</td>
</tr>
<tr>
<td>Propose to continue to use and develop community hub services</td>
<td>✓</td>
<td></td>
<td></td>
<td>&lt;&lt;&lt; develop the site</td>
</tr>
</tbody>
</table>

**What the table shows...**

Taking account of the proposed changes to Specialist OPMH, Dementia day units and community bedded care:

- Bolsover site would be used for only a small number of attendances (c.2,300) and have very low utilisation (8% of clinical space). It would therefore be very costly to run to deliver the residual levels of care (£325 per attendance excluding cost of care).
- Clay Cross site would be used for a high number of attendances (c.22,600) and have a higher utilisation (27% of clinical space). The site is also extensively used as a base for other local clinical service teams. It would provide a cost effective site (£18 per attendance excluding cost of care).
- Newholme site would be used for a significant number of attendances (c.12,500) but have a low utilisation (18% of clinical space). The site is used to provide corporate office space but which could be relocated elsewhere with no impact on patients. It would be a costly site to run (£49 per attendance excluding cost of care).

**Conclusions**

- **Propose to close sites at Bolsover and Newholme to save (c.£0.9m p.a. net of site re-provision costs) which can be reinvested in care provision i.e. get better value for money.**
- **Commit to continue to deliver those services locally within the community.**
Impact on ‘stranded costs’ identified in the proposed OPMH and community bedded care changes

The tables show the phased impact of the proposed service and site changes.

**OPMH proposed changes...**

<table>
<thead>
<tr>
<th>Proposed service:</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Specialist OPMH (Walton)</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
<td>5,618</td>
</tr>
<tr>
<td>(ii) Dementia Rapid Response Team</td>
<td>0</td>
<td>416</td>
<td>1,588</td>
<td>2,351</td>
<td>2,433</td>
<td>2,515</td>
</tr>
<tr>
<td>(iii) Other OPMH ward costs</td>
<td>3,082</td>
<td>2,000</td>
<td>1,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total proposed service</strong></td>
<td>8,700</td>
<td>8,034</td>
<td>8,206</td>
<td>7,969</td>
<td>8,051</td>
<td>8,133</td>
</tr>
</tbody>
</table>

- 'Stranded' other overheads, site costs
  - (i) Newholme OPMH site costs                        | 220      | 220    | 110    | 0      | 0      | 0      |
  - (ii) Cavendish OPMH site costs                      | 220      | 220    | 220    | 220    | 220    | 220    |
  - (iii) Other corporate overheads                    | 616      | 616    | 616    | 616    | 616    | 616    |
| **Total 'Stranded' other overheads, site costs**     | 1,056    | 1,056  | 946    | 836    | 836    | 836    |

- **Total (incl. stranded costs)**                     | 9,090    | 9,262  | 8,915  | 8,887  | 8,969  |

**Community bedded care...**

<table>
<thead>
<tr>
<th>Proposed service:</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Specialist rehab beds</td>
<td>0</td>
<td>0</td>
<td>2,300</td>
<td>3,407</td>
<td>3,407</td>
<td>3,407</td>
</tr>
<tr>
<td>(ii) Local intermediate care beds</td>
<td>1,470</td>
<td>1,696</td>
<td>2,772</td>
<td>2,882</td>
<td>2,998</td>
<td>2,989</td>
</tr>
<tr>
<td>(iii) Community Integrated Care Service (ICS)</td>
<td>0</td>
<td>1,430</td>
<td>2,888</td>
<td>3,091</td>
<td>3,145</td>
<td>3,598</td>
</tr>
<tr>
<td>(iv) Other existing direct bedded care costs</td>
<td>10,349</td>
<td>7,500</td>
<td>1,730</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total proposed service</strong></td>
<td>11,819</td>
<td>10,626</td>
<td>9,690</td>
<td>9,380</td>
<td>9,550</td>
<td>9,994</td>
</tr>
</tbody>
</table>

- 'Stranded' other overheads, site costs:
  - Bolsover comm beds site costs                      | 450      | 0      | 0      | 0      | 0      | 0      |
  - Cavendish comm beds site costs                     | 220      | 220    | 220    | 220    | 220    | 220    |
  - Clay Cross comm beds site costs                    | 320      | 320    | 320    | 320    | 320    | 320    |
  - Newholme comm beds site costs                      | 220      | 220    | 110    | 0      | 0      | 0      |
  - Whitworth comm beds site costs                     | 350      | 350    | 350    | 350    | 350    | 350    |
  - Other corporate overheads                          | 1,040    | 740    | 540    | 540    | 171    | 171    |
| **Total 'Stranded' other overheads, site costs**     | 2,600    | 1,850  | 1,540  | 1,430  | 1,061  | 1,061  |
Site rationalisation – Benefits and Summary

The proposed changes would see services continue to be delivered within local communities but would make better use of resources c.£0.9m per annum. No sites will close until appropriate alternatives services are available locally. Other sites will be subject to ongoing review as other services proposals developed (e.g. related to urgent care provision).

Proposals will be subject to support from Commissioners, review and approval by Provider Boards who own the assets. Proposals will then also form part of the Public Consultation.

Quality benefits

• Current outpatient / clinic based services or appropriate alternatives will continue to be delivered within local communities.
• Alternatives sites would be selected to be accessible and to help join up care services – in keeping with the aim to develop community hubs and networks.

Financial benefits

• The proposed changes would deliver a net cost saving per annum of c.£0.9m.
• So instead of spending this money on costly and outdated buildings, it will instead be invested in care provision i.e. getting better value for money.

Workforce implications

• The workforce implications of other proposals forming part of this PCBC are described elsewhere in this PCBC.
• In addition, staff currently providing patient services (outpatients / clinics) may also be impacted – needing to deliver care from alternative local sites. This will be considered further following consultation.
• And, staff currently providing ‘site services’ (estates, ancillary, etc.) would also be affected.
• Workforce development principles will apply to all staff impacted by the proposed changes – it would be the intention that ‘staff will be retained, retrained and redeployed wherever possible’.

So what is being proposed (subject to consultation)...

i. To close sites at Bolsover and Newholme to save c.£0.9m p.a. (net of site re-provision costs) which can be reinvested in care provision i.e. get better value for money.

ii. A commitment to continue to deliver services locally within each community.

iii. To continue to review other sites as other services proposals are developed.

These proposals are subject to:

• Support from Commissioners;
• Review and approval by Provider Boards who own the assets;
• Proposals will form part of the Public Consultation.
Processes used to develop the proposals

This section describes the processes by which the proposals were developed:

1) Engaging stakeholders in the development of the proposals
2) How preferred options were identified
3) NHS-E assurance (‘the 4 tests’)  
4) Equality assurance
Communications and engagement

The North Derbyshire 21st Century - # joined up care programme has undertaken substantial engagement with a wide range of stakeholders and public since it commenced pre consultation in 2012. This ongoing dialogue has informed the development of the programme as a whole and underpinned co-creation of the proposed changes.

Introduction and context

Since pre consultation commenced in 2012, the North Derbyshire 21st Century - # joined up care programme has undertaken substantial engagement with a wide range of stakeholders and public. The information in this section provides an overview of the engagement activities during this period. A full report is provided in the appendix that also includes responses the programme has received during this period and explains how they have informed the development of the wider programme and the specific changes proposed in this business case.

Throughout the pre-consultation period, the programme has undertaken comprehensive engagement with stakeholders, patients, public, clinicians and professionals at a ‘system’ level and at a ‘local’ level in each of the 8 communities. These activities have been to establish, develop and influence the vision, case for change, future models of care and the development of viable options that can be taken forward to consultation.

The more recent pre-consultation activities looking at alternative options for care delivery have very much focused on the ‘Community Hubs’ element of the plan, and it is these that are presented in the Pre Consultation Business Case.

Engagement method and approaches

Reflecting experience from other consultations, best practice guidance, the NHS England Assurance Process and the Equality Act 2010, a communications and engagement strategy was produced by the Communications and Engagement Working Group to guide and shape the Programme’s public and stakeholder engagement. Development of this strategy was based around the need to engage with three key groups:

- Patients and the public;
- Clinicians and professionals; and
- Health Overview & Scrutiny Committee, Health & Wellbeing Board and wider political engagement.

To further support the implementation of this strategy against each of the three key groups the Communications and Engagement Working Group developed a stakeholder map to further shape the implementation of the communication and engagement strategy and work programme. An overview of the communications and engagement strategy is described below.

<table>
<thead>
<tr>
<th>1. Vision &amp; Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Case for change and emerging ideas</td>
</tr>
<tr>
<td>3. Co-create alternative care models</td>
</tr>
<tr>
<td>4. Communicate proposed changes</td>
</tr>
</tbody>
</table>

- Commissioner / Provider planning sessions
- Public meetings
- Focus groups
- HOSC & HWBB
- Newsletters and bulletins
- Web and social media
- 1-2-1 media briefings
- Lay reference group
- Staff briefings
- 1-2-1’s with key stakeholders
## Communications and engagement

The table below provides a summary of what the communications and engagement strategy proposed and what has been delivered so far.

### Overview of what has been delivered...

<table>
<thead>
<tr>
<th>What was planned in the strategy</th>
<th>Summary of what we have delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commissioner / Provider planning sessions</strong></td>
<td>The Future of Services in North Derbyshire: A half-day visioning session with Clinicians, Professionals and Voluntary Sector x1</td>
</tr>
<tr>
<td><strong>Public meetings</strong></td>
<td>Events to launch vision and agree guiding principles x3</td>
</tr>
<tr>
<td><strong>Focus groups with a wide range of stakeholders</strong></td>
<td>Sessions with small voluntary, self help and advice groups x 63</td>
</tr>
<tr>
<td><strong>Clinical and Professional Guidance and Advice</strong></td>
<td>East Midlands Clinical Senate confirm and challenge x1</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>Commissioning Delivery Group (CDG) in Hardwick CCG x7</td>
</tr>
<tr>
<td><strong>HOSC &amp; HWBB</strong></td>
<td>Paper to Shadow HWBB x1</td>
</tr>
<tr>
<td><strong>Local council meetings</strong></td>
<td>Events to launch vision and agree guiding principles x3</td>
</tr>
<tr>
<td><strong>Proactive press releases</strong></td>
<td>30 (Ongoing)</td>
</tr>
<tr>
<td><strong>Tweets/Facebook posts</strong></td>
<td>3,301 (Ongoing)</td>
</tr>
<tr>
<td><strong>Social media audience reach</strong></td>
<td>119,947 (Ongoing)</td>
</tr>
<tr>
<td><strong>Video Views (YouTube)</strong></td>
<td>3,945 (Ongoing)</td>
</tr>
<tr>
<td><strong>Stakeholder newsletter</strong></td>
<td>2,000 (Ongoing)</td>
</tr>
<tr>
<td><strong>Staff face to face</strong></td>
<td>2,270 (Ongoing)</td>
</tr>
<tr>
<td><strong>Staff materials audience</strong></td>
<td>35,012 (Ongoing)</td>
</tr>
<tr>
<td><strong>E-news audience</strong></td>
<td>12,263 (Ongoing)</td>
</tr>
</tbody>
</table>

Community Hub Working Group within each of the eight communities to consider and develop alternative models of care x73

Public meetings to develop the dialogue around the changing health and care needs of the population and pressures faced x8

Open public meetings to discuss the reasons for change and the developing alternative care, and receive feedback x8

Public focus groups to test emerging ideas on alternative ways of providing care x4

• Clinical and Professional Reference Group confirm and challenge x7
  • Options cross-system read-across x2

• Commissioning Delivery Group (CDG) in Hardwick x7
  • Community Hub Working Group within each of the eight communities (representative GPs) to consider and develop alternative models of care x73
  • Special Locality Workshops x6
  • NDCCG Membership Workshop x1
  • Membership Locality Meetings x50
  • Practice Manager Meetings x2

• Regular updates and Papers to HWBB and Core Group x2
  • Regular updates to HOSC x4 and Special Meeting x1

• Derbyshire Partnership Forum x1
  • Bolsover Partnership x1
  • Parish Council Liaison Group x1
  • Attended LAC x5

Attended LAC x5
Wide spread engagement to develop the vision, case for change and emerging ideas
Following the start of pre-consultation in 2012, over two years was spent talking with and listening to stakeholders and the public in order to establish, develop and shape the vision, case for change and emerging ideas for joined up health and care services

Public meetings
From the very start there has been a commitment to working in partnership with local people and communities to develop safe and sustainable services that meet the changing needs of people within the resources available. To support these initial conversations with the public a document was produced that set out the case for change together with a draft set of nine principles.
During 2012 Hardwick CCG and North Derbyshire CCG (in their shadow form), together with partner health and social care organisations, began engaging with the North Derbyshire community about the changing face of health and care provision and the draft principles. This was done through a combination of three public events and a questionnaire.

Building on the events in 2012, eight public meetings were held in 2014 across North Derbyshire to continue to develop the dialogue around the changing health and care needs of the population, skills shortages, poor estate, financial pressures and the need for much more integrated working. These events also provided further opportunities to present the vision for a much more integrated health and care system and share emerging ideas for alternative ways of providing care.

Small Voluntary, self help and advice groups
In addition to the larger public meetings numerous meetings were held with support and advice groups across the 8 communities to discuss the issues and challenges facing the health and care system in North Derbyshire. At these meetings, health and care system leads highlighted the challenges services were grappling with – changing needs of people where increasingly the ageing populations’ needs are ongoing and complex, skills shortages, poor estate, financial pressures and the need for much more integrated working – and listened to the views of those attending. These sessions also provided the opportunity for health and care leads to share successes already achieved and test emerging ideas for better ways of delivering health and social care. A total of 63 group meetings were held which had 1,200 attendees.

Clinical and Professional Reference Group (CPRG)
A key component of the clinical and professional engagement approach for the 21st Century Programme is the North Derbyshire Clinical and Professional Reference Group (CPRG). This group meets monthly and is attended by the clinical leads from both commissioner and provider healthcare organisations as well as professional leadership from Adult Social Care. CPRGs core purpose is to act as a confirm and challenge group providing clinical and professional recommendations to the Programme Delivery Group. This group has been pivotal in the development and consideration of the case for change and emerging ideas for service redesign.

East Midlands Clinical Senate
The East Midlands Clinical Senate provided independent clinical advice to the developing Community Hub plans as part of the NHS England assurance process. The Clinical Senate reviewed the case for change and planned approach to the development of Community Hubs, and answered the following questions:
  i) Is the vision in North Derbyshire for developing the options for integrated out of hospital based care, based on sound evidence and best practice?
  ii) Does the local evidence base and modelling assumptions support the proposed scale of change in relation to community bedded care?

The Clinical Senate panel supported the view that the vision in North Derbyshire for integrated out of hospital care is based on sound evidence and best practice. The panel also supported the view that, the local evidence base and modelling assumptions support the proposed scale of change.

Health Overview and Scrutiny, Health and Well-Being Board, and Local Area Committees
Throughout the pre-consultation period regular meetings, briefings and presentations have been made to Health Overview and Scrutiny, Health and Well-Being Board and Local Area Committees to ensure they are up to date and fully informed on the vision case for change and emerging ideas for joined up health and care services.
Wide spread engagement to co-create alternative care models
To ensure the proposed models and options for delivery were understood and owned by the public, clinicians and professionals, more recent engagement activity has focused on the co-creation of alternative care models

Community Hub Groups in each community
Across each of the eight communities a multi-agency Community Hub Group (each with membership from the public, voluntary sector, primary care, clinicians and professionals from social care) was set up to lead the development of Community Hubs within that area. These groups played a key role in developing and refining the vision and concept of Community Hubs, as well as defining the models of care and alternative options for delivery for Older Peoples Mental Health, Bedded Care and Urgent Access to Care.

Each group within each community met nine times between December 2014 and February 2016 to consider the vision for future health and care services, refine the case for change, and develop alternative care models.

Community focus groups
Four community focus groups were held across North Derbyshire. These were not open public sessions; members of the public and patients were invited who had heard the case for change and understood the proposed direction of travel. These sessions built on previous discussions with the public by further refining the case for change and sharing emerging ideas on alternative ways of providing care to better meet the needs of local people. These sessions also provided an opportunity to test and share the criteria to be used to appraise the options for any new models of care and gain advice and ideas about the best way to engage the wider public in open sessions.

Public meetings
In addition to the focus group sessions, eight open public meetings were held in each community. The purpose of these events was to engage a wider range of members of the public to discuss the direction of travel. These sessions provided attendees with an opportunity to further understand the reasons for change and the alternative care models developed by the Community Hub Groups in the 8 communities. Attendees were encouraged to provide feedback, especially identifying areas for improvement. Real examples were shared by means of a ‘market stall’ at each of the meetings about how the NHS and Adult Social Care are already working together to deliver services either in people’s homes or much closer to their homes in a more integrated way.

Clinical and Professional Reference Group (CPRG)
In addition to supporting the development of the case for change, the North Derbyshire Clinical and Professional Reference Group continued to be pivotal in the co-creation of alternative care models. CPRG agreed the new models of care for Older Peoples Mental Health and Community Rehabilitation beds as well as providing challenge to and confirmation of the conclusions from the cross-system read across evaluations.

Cross-system evaluation of short list options
A core component of the process to identify preferred alternative models of care has been two ‘cross-system’ evaluation workshops. The first of these focused on an evaluation of the short list of options for community bedded care and OPMH beds. The second session considered the site implications as a result of the proposed changes to the way community rehabilitation beds and dementia care is provided. These sessions were attended by a good cross-section of clinicians, professionals, voluntary sector representatives, lay representatives and managers.

General Practitioners and Primary Care
To ensure the vision, case for change and emerging alternative models of care have been discussed with and informed by General Practitioners and Primary Care through out the process, a number of forums have been used including locality meetings, the Primary Care Commissioning Delivery Group and Membership Events.
Determining the specialist OPMH and Community Rehabilitation care options for implementation

A structured process enabled the Community Hub Groups to move through the development and ‘funnelling’ of an initial broad range of potential options for the future provision of OPMH and Community Bedded care down to a small number of options which were analysed and considered in appropriate detail. This process is described below...

Overview of process for specialist OPMH and Community Rehabilitation care

The initial focus for developing and evaluating alternative options for delivering care was specialist OPMH services and Community Rehabilitation care. Central to the delivery of this process were the Community Hub Groups in each of the eight communities which did the majority of the ‘thinking’ around the options, together with the Community Hubs Working Group and the Clinical and Professional Reference Group which provided challenge and confirmation throughout the process. The final evaluation of the options was carried out by a ‘cross-system’ group made up of clinicians, professionals, voluntary sector representatives, lay representatives and managers.

As well as identifying a preferred option from the short list, the process also identified the need to carry out further evaluations on the future provision of Dementia Day Unit Services and the implications of proposed changes to sites. An overview of this process together with where each of the groups played a role is described below.

The key considerations and conclusions from this process are described further over the next pages.
Determining alternative models of care
The process was directed by a set of agreed principles and objectively evaluated on the basis of a set of agreed criteria. Models of care were defined and agreed prior to determining how and where care should be delivered.

Options for alternative models of care
The case for change for developing future OPMH and Community Rehabilitation care models was clearly stated in the Community Hubs Strategic Outline Case. Building on this document, a set of bedded care principles were developed by the Community Hubs Working Group; and reviewed by the Clinical and Professional Reference Group (CPRG) before being provided to the Community Hub Groups in the eight communities to guide the consideration of alternative options.

Bedded care principles
1) Consideration of where and how bedded care should be delivered must always start from how best to meet the whole persons needs in an integrated way.
2) Bedded care needs should be considered as part of a pathway; supported by integrated working and improved coordination of care.
3) The need for bedded care should be determined by:
   i. the frequency, duration and nature of care AND
   ii. the need to access to specialist capabilities
4) Bedded care should only be provided:
   i. where the care is not possible in the persons own home; or,
   ii. where better value (quality, safety &/or cost) can be provided to the patient and services from the care being provided in coordinated locations.
5) Demand for bedded care varies over time; therefore bedded capacity must be flexible to adapt to meet demand.
6) Technology should be used to bring expertise to the patient rather than physically needing to bring the patient and experts together.
7) Bedded capacity should be organised to maximise utilisation of resources across health and social care; and reduce demarcation of bed types.

In light of the bedded care principles developed and consideration given by the Community Hub Groups in the eight communities, care models for specialist OPMH and Community Rehabilitation were developed.

Specialist OPMH
- Community Dementia ‘Rapid Response’ Teams providing support to people with Dementia and their families; supported by fewer OPMH beds in specialist unit(s).
- Community dementia teams provide an alternative community based service model available 7 days a week, 365 days a year to respond to situations that might otherwise lead to hospital admissions and keep people in the place they call home, providing skilled and rapid assessment, access to specialist prescribing, and design and provision of short-term input.
- OPMH beds operate 24/7/365 to deliver specialised multi-disciplinary assessment and treatment and to arrange suitable post-hospital care.
- Dedicated specialist Consultant Psychiatrist input; supporting both the bedded care and Dementia Rapid Response Teams in the community.

Community Rehabilitation
- Once medically stable, if further reablement or rehabilitation support is required
- Consistent, differentiated care based on standards, criteria and thresholds delivered as part of a system of tiered care to support people home from acute hospitals or provide ‘step up’ care
- The default care setting for all patients should be home however it’s recognised some patients needs will place them beyond the thresholds for safe care at home

<table>
<thead>
<tr>
<th>Specialist Rehabilitation</th>
<th>Community Intermediate Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Based</td>
<td>Rehabilitation / Re-ablement at home/ place called home/ in community bed.</td>
</tr>
<tr>
<td>Patient needs higher clinical input</td>
<td>Integrated Care Team management and or support (7/365)</td>
</tr>
<tr>
<td>24/7 Registered Nursing Care</td>
<td>24/7 access to Urgent Care Services</td>
</tr>
<tr>
<td>Intensive Rehabilitation</td>
<td>Usually up to 2 weeks with a maximum of 6 weeks</td>
</tr>
<tr>
<td>Discharge support plan work-up</td>
<td>Discharge support plan work-up</td>
</tr>
<tr>
<td>Up to 3 weeks but usually less</td>
<td>Followed by discharge or other outcome</td>
</tr>
<tr>
<td>Followed by step down to either Community Intermediate Care or Discharge to other outcome</td>
<td></td>
</tr>
</tbody>
</table>
Establishing the preferred model of care
The alternative care models developed were assessed against the status quo to confirm whether they were deemed to be better alternatives...

Preferred model of care
To consider whether each of the alternative models of care identified for specialist OPMH and Community Rehabilitation were better than the current models they were each assessed against the following criteria (compared to ‘Do Nothing’):

- People kept at home and independent wherever possible
- Consistent with local and national strategic direction
- Consistent with available clinical evidence and best practice (safe/effective)
- Improved access to care
  - Access to services (Right Care, Right Place, Right Time, services meet local needs)
  - Develops and supports service user choice
- Improved service effectiveness and efficiency
  - Affordability
  - Supports service and workforce resilience

A description of the approach to developing the criteria and how it was applied is described in the appendix.

The assessment was carried out by the Community Hubs Working Group and confirmed at the Cross-System Read across session.

To inform the comparison of the proposed models of care against the status quo and assess them against the criteria a suite of analysis was produced covering:

- Clinical / Quality
- Activity, travel time and cost
- Workforce
- Estates
- Strategic fit/ Implementation

The outcomes of this evaluation are described in the tables opposite.

The analysis underpinning the outcomes is provided in the appendix.
Establishing the long list and short list for delivering the preferred models

Having agreed the preferred models of care for Specialist OPMH and Community Rehabilitation, consideration turned to identifying the list of options for how they could be delivered...

Long list of delivery options

For specialist OPMH a long list of eight options was identified through the Community Hub Groups in each of the communities for the provision of the OPMH beds in specialist units component of the preferred model of care.

1. Status Quo – 3 locations; Walton Hospital, Cavendish Hospital, Newholme Hospital
2. Single facility at Cavendish Hospital
3. Single facility at Walton Hospital
4. Single facility at Chesterfield Royal Hospital
5. Two facilities at Walton Hospital and Cavendish Hospital
6. Two facilities at Chesterfield Royal Hospital and Cavendish Hospital
7. Two facilities at Walton Hospital and Newholme Hospital
8. Two facilities at Newholme Hospital and Cavendish Hospital

All of the options would be delivered with the Dementia Rapid Response Team.

For Community Rehabilitation the picture was slightly more complicated given the preferred model of care. A long list of potential site options was drawn up for the provision of the Specialist Rehabilitation Beds component of the model of care, which in combination had a vast set of possible options.

1. Bolsover Hospital
2. Buxton Hospital
3. Cavendish Hospital
4. Clay Cross Hospital
5. Walton Hospital
6. Chesterfield Royal Hospital
7. Newholme Hospital
8. Whitworth Hospital

It was agreed that for the local Intermediate Care Bed component of the model each Community Hub Group would assess whether they wanted these provided locally within the community or in consolidated units across communities.

Short list of delivery options

Having established the long list of options for Specialist OPMH beds and Specialist Community Rehabilitation beds the Community Hub Groups in each community considered them in light of the evaluation criteria and analysis to date to establish the short list of options for more detailed assessment. This wasn’t a full evaluation of all options (this would certainly have been unfeasible in light of the vast range of possible combinations for Specialist Rehabilitation beds), rather a considered view based on the criteria, professional knowledge and analysis to date.

The short lists were signed-off by the Clinical and Professional Reference Group. The short lists that were evaluated are described below.

Specialist OPMH beds

Each option included Walton as it is already specialist purpose built facility servicing the majority of the population:

- Option 1 - 3 locations; Walton Hospital, Cavendish Hospital, Newholme Hospital (Status Quo)
- Option 2 - Single facility at Walton Hospital
- Option 3 - Two facilities at Walton Hospital and Cavendish Hospital
- Option 4 – Two facilities at Walton Hospital and Newholme Hospital
- Option 5 – Two facilities at Walton Hospital and Whitworth Hospital

Specialist Rehabilitation beds

Options needed to consider that the total number of beds required was 32 so more than 2 units was unlikely to be viable clinically nor financially:

- Option 1 - 5 locations; Whitworth Hospital, Cavendish Hospital, Clay Cross Hospital, Bolsover Hospital, Newholme Hospital (Status Quo)
- Option 2 - Single facility at Chesterfield Royal Hospital
- Option 3 - Single facility at Whitworth Hospital
- Option 4 – Two facilities at Chesterfield Royal Hospital and Cavendish Hospital
- Option 5 – Two facilities at Cavendish Hospital and Whitworth Hospital
- Option 6 – Two facilities at Cavendish Hospital and Clay Cross Hospital
- Option 7 – Two facilities at Cavendish Hospital and Bolsover Hospital
Identifying the preferred new delivery model

With the short list of options for delivery identified, the final step in the process was an evaluation of each option by a ‘cross-system’ group against the criteria...

Preferred delivery model

To consider the short list of alternative delivery options for Specialist OPMH beds and Specialist Rehabilitation Beds, a ‘cross-system’ group of clinicians, professionals, voluntary sector representatives, lay representatives and managers was brought together to assess them against the following criteria:

- People kept at home and independent wherever possible
  - Consistent with available clinical evidence and best practice (safe/effective)
- Improved access to care
  - Access to services (Right Care, Right Place, Right Time, services meet local needs)
  - Develops and supports service user choice
- Improved service effectiveness and efficiency
  - Affordability
  - Supports service and workforce resilience

A description of the approach to developing the criteria and how it was applied is described in the appendix.

To inform the comparison of the potential options against the criteria, a suite of analysis was produced covering:

- Clinical / Quality
- Activity, travel time and cost
- Workforce
- Estates
- Strategic fit/ Implementation

The outcome of this evaluation are described opposite and a summary of the evaluation of all options provided on the next page.

The analysis underpinning the outcomes is provided in the appendix.

Specialist OPMH beds

The preferred option for Specialist OPMH beds that came from the evaluation was Option 2 – Single facility at Walton Hospital.

Key considerations were:

- A single specialist facility in Walton would mean a small number of patients and their families need to travel further. However this is out-weighted by services being provided from a single Centre of Excellence, and overall travel would be significantly reduced as with the new model far less people would be admitted to hospital.
- Full Psychiatrist 24 hour cover would be achievable and sustainable from a single location, therefore providing better quality care.
- From a carers and relatives perspective the view was additional travel time would be justifiable where more specialist care is required in a suitable environment and the quality of care can be assured.

Specialist Rehabilitation beds

The preferred option for Specialist Rehabilitation beds that came from the evaluation was Option 4 – Two facilities at Chesterfield Royal Hospital and Cavendish Hospital.

Key considerations were:

- The preferred option was considered to be the ‘best balanced’
- A two site options was seen preferential to a one site options due to
  - The flow of patients into these beds is typically following an acute (specialist care) episode and is part of transitional care back to a patients own community
  - A highly specialised workforce that is in short supply is not required
Summary of evaluation of short list of options – Specialist OPMH beds

The evaluation of the alternative options for the delivery of the specialist OPMH beds at the cross system review comprised of three steps:

**Step 1**
Each participant at the session individually scored each option against the criteria using the following scale:

<table>
<thead>
<tr>
<th>Low Evaluation</th>
<th>0</th>
<th>High Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- - -</strong></td>
<td><strong>0</strong></td>
<td><strong>++ + +</strong></td>
</tr>
</tbody>
</table>

**Step 2**
Each participant then went to the front of the room where a large evaluation sheet was up on the wall. They placed a ‘dot’ on the sheet for each option-criterion combination where they scored a ‘++’.

**Step 3**
As well as placing a ‘dot’ where a ‘++’ had been scored, each participant also placed a ‘dot’ against which option they preferred overall.

### Table: Summary of Evaluation of Options

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Option 1 (3 existing facilities (Walton, Newholme, Cavendish))</th>
<th>Option 2 (1 facility @ Walton)</th>
<th>Option 3 (2 facilities @ Walton and Cavendish)</th>
<th>Option 4 (2 facilities @ Walton and Newholme)</th>
<th>Option 5 (2 facilities @ Walton and Whitworth)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People kept at home and independent wherever possible</td>
<td>Consistent with available clinical evidence and best practice (safe / effective)</td>
<td>Access to services (Right care, right place, right time, services meet local needs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved access to care</td>
<td></td>
<td>Develops and supports service user choice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved service effectiveness and efficiency</td>
<td></td>
<td>Affordability (including physical access statutory compliance)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supports service and workforce resilience</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preferred Option**

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
The same three step evaluation process was used for the Specialist Rehabilitation Beds as was used for OPMH Specialist Beds.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>People kept at home and independent wherever possible</td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
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<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
</tr>
<tr>
<td>Improved access to care</td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
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<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
</tr>
<tr>
<td>Improved service effectiveness and efficiency</td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
<td><img src="#" alt="Evaluation Score" /></td>
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</tbody>
</table>

| Preferred Option                      | ![Evaluation Score](#) | ![Evaluation Score](#) | ![Evaluation Score](#) | ![Evaluation Score](#) | ![Evaluation Score](#) | ![Evaluation Score](#) | ![Evaluation Score](#) |
Determining the alternative OPMH Day Unit services options for implementation
The proposed service changes for older peoples mental health day unit services are the result of reviewing the current approach to delivering these services in light of the proposed new delivery model for Older Person’s Mental Health Dementia beds and Dementia Rapid Response Team, and feedback from stakeholders.

- Proposed new delivery model for consultation – Specialist OPMH and Community Rehab
  - Signed off by Clinical and Professional Reference Group
  - Signed off by Programme Delivery Group
  - Fed back at Community Hub Group meetings x8

- Consideration of feedback from stakeholders
  - Members of Community Hub Groups and attendees at the cross-system review, flagged questions around the future provision of OPMH Day Units in light of the proposed new model of care for specialist OPMH services
  - Agreement by the Community Hubs Working Group and Programme Delivery Group more work is required

- Options for alternative models of care for OPMH Day Unit services
  - Day Unit Working Group reviewed current model of care, considered best practice and identified alternatives
  - Alternative models discussed with Community Hubs Working Group

- Preferred model of care for OPMH Day Unit services
  - Day Unit Working Group identify preferred model
  - Signed off by Clinical and Professional Reference Group
  - Discussed with Community Hub Groups
  - Signed off by Programme Delivery Group
Determining the alternative options for other services delivered from sites affected by the proposals

The other service proposals were developed in light of the proposed changes to specialist OPMH and community bedded care which were identified as having a significant impact on the configuration of services delivered from affected sites within each of the communities.

- Signed off by Clinical and Professional Reference Group
- Signed off by Programme Delivery Group
- Fed back at Community Hub Group meeting 8

**Proposed new delivery model for consultation – Specialist OPMH and Community Rehab**

**Impact on current sites**
- Described within PCBC (Stage 2)
- Reviewed with CCG & Provider Boards

**Implications for community hospital sites**
- Community Hubs Working Group - evaluate site implications (vs criteria)
- Capacity required (type & space)
- Site utilisation
- Site costs
- Site flexibility
- Consideration of the feasibility of alternatives (incl. estimated cost)

**Site rationalisation requirements / opportunities**
- Cross System Review – “confirm and challenge”
- Described within Full PCBC (Stage 3)
- For approval by Provider Board(s); support by CCG Boards

**Site rationalisation proposals for consultation**
- Community Hub Group (x 8) reviews

**Evaluation of alternatives by Community Hubs Working Group using criteria**
Four Tests for Service Change – Summary

The ‘Planning, assuring and delivering service change for patients’ guidance (NHS England; Nov. 2015), reiterated the four tests for service change as part of the Government Mandate to the NHS. This Mandate requires CCGs to exercise their commissioning functions consistently with the objectives in the mandate.

The service change proposals for Community Hubs as set out in this PCBC have been assessed against the four tests to ensure the CCGs are meeting the requirements; the summary of which is provided below.

<table>
<thead>
<tr>
<th>How have we met this test?</th>
<th>(1) Clear, clinical evidence base and best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The proposals are based on clinical evidence and experience. The development of the models of care has been clinically led through Clinical &amp; Professional Reference Group. This group; core to the process and decision making, was made up of system clinical leaders with local subject matter experts brought in as required.</td>
</tr>
<tr>
<td></td>
<td>Clinical involvement in the Community Hub Groups (lead GPs and community service clinicians) in the development of the options; and primary, community and secondary care clinician involvement in the cross system reviews, meant wide ranging clinical perspectives and opinions have informed the proposals throughout.</td>
</tr>
<tr>
<td></td>
<td>Examples of guidance and best practice which the proposals are consistent with, include:</td>
</tr>
<tr>
<td></td>
<td>• ‘NHS Five Year Forward View’ (NHS England, October 2014)</td>
</tr>
<tr>
<td></td>
<td>• ‘Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders’ (NHS England, February 2014)</td>
</tr>
<tr>
<td></td>
<td>• ‘Making our health &amp; care systems fit for an aging population’ (The Kings Fund, March 2014)</td>
</tr>
<tr>
<td></td>
<td>• ‘Specialists in out-of-hospital settings (The Kings Fund, October 2014)</td>
</tr>
<tr>
<td></td>
<td>• ‘Support. Stay. Save. Care &amp; Support of People with Dementia in their own homes’ (Alzheimer’s Society, Jan 2011)</td>
</tr>
<tr>
<td></td>
<td>An independent review of the vision and planning assumptions was undertaken by the East Midlands Clinical Senate in June 2015. The purpose was to seek independent scrutiny of the proposals to confirm they were based on sound clinical evidence and best practice. The review panel supported the view that the vision in North Derbyshire for developing the options for integrated out of hospital based care is based on sound evidence and best practice. The review panel also supported the view that the local evidence base and modelling assumptions support the proposed scale of change in relation to community bedded care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How have we met this test?</th>
<th>(2) Consistency with current and prospective need for patient choice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In relation to Community Services, which are the scope of the proposals included in this PCBC; the ‘2015/16 Choice Framework ’ (Department of Health; March 15) confirms these services are not a legal right of choice for patients and states ‘you are not generally able to choose from services outside of your local area unless special arrangements are in place to support this.’ That said, patient choice has been considered in the development of the proposals in terms of patient preferences and their choice of where and how they receive care.</td>
</tr>
<tr>
<td></td>
<td>Based on local public feedback from the engagement events to date (also see 3. Strong Public &amp; Patient engagement) there is a clear view that people would choose to receive their care in or as close to ‘the place they call home’. The proposals which have been developed in response to that feedback, enhance this choice by developing the community support teams to bring care closer to home.</td>
</tr>
<tr>
<td></td>
<td>The focus on integration to bring services together is intended to improve coordination. By having the community support wrapped around patients and their carers, the care pathway will be enhanced; helping people make more informed choices about their care. In terms of bedded care, these choices would be informed by the patient/carers ability to cope and their situation which would determine where that care could be provided.</td>
</tr>
<tr>
<td></td>
<td>In addition; the ongoing Community Hub/Network considerations and the development of the urgent care proposals will continue to take patient choice into account as appropriate.</td>
</tr>
</tbody>
</table>
### Four Tests for Service Change – Summary continued

<table>
<thead>
<tr>
<th>(3) Strong Public &amp; Patient engagement</th>
<th>(4) Support for proposals from GP commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How have we met this test?</strong></td>
<td><strong>How have we met this test?</strong></td>
</tr>
<tr>
<td>From the very start there has been a commitment to working in partnership with local people and communities to develop safe and sustainable services that meet the changing needs of people within the resources available. In summary, to date we have:</td>
<td>Member Practices of both CCGs have been consistently involved in the wider 21C JoinedUpCare process and in the development of the Community Hub options which have emerged.</td>
</tr>
<tr>
<td>• Undertaken ongoing pre-consultation engagement and communication since 2012 to ensure continuous dialogue with stakeholders, the public and patients to inform, develop and influence the vision, case for change, future models of care and the development of viable options for consultation. This has included;</td>
<td>Regular updates have been provided to both CCG Governing Bodies (and partner organisations) to ensure progress was supported and enable continuous feedback to be incorporated.</td>
</tr>
<tr>
<td>• Public Launch Events: Vision (2012; 86 attendees and 185 questionnaires)</td>
<td>The approach taken was not simply to seek GP Commissioner sign off of the proposals once developed; it was a continuous approach which has directly involved Governing Body GPs and Member Practices in the developments. In summary this has involved discussions at:</td>
</tr>
<tr>
<td>• Public meetings in the 8 communities: Case for change and emerging ideas (2014; 175 attendees)</td>
<td>• Locality Meetings</td>
</tr>
<tr>
<td>• Community Focus Group events (x8) and open public meetings: Co-create alternative models of care (2015; 562 attendees)</td>
<td>• Primary Care Commissioning Delivery Group</td>
</tr>
<tr>
<td>• Proactive press releases (x30)</td>
<td>• Integrated Steering Group</td>
</tr>
<tr>
<td>• 3,301 website visitors</td>
<td>• Sharing &amp; Learning Event (Apr 15)</td>
</tr>
<tr>
<td>• 244 Tweets/ Facebooks posts</td>
<td>• Membership Event (Sept 15)</td>
</tr>
<tr>
<td>• Social Medial Audience reach 119,947</td>
<td>• North Derbyshire Clinical Reference Group (specific session to challenge and confirm developments, Oct 15)</td>
</tr>
<tr>
<td>• 3,945 You Tube Video Views</td>
<td>More specific GP Commissioner involvement and support of the proposals, has been through the 8 Community Hub Groups; which had at least 2 lead GPs as members representing each community.</td>
</tr>
<tr>
<td>• Street Campaign audience (748 people)</td>
<td>The group responsible for clinical oversight of the developments is the Clinical &amp; Professional Reference Group; this meeting was chaired by the CCG Chairs.</td>
</tr>
<tr>
<td>• E-news Audience (12,263)</td>
<td>Ultimately, the proposals in the PCBC have been taken to both CCG Governing Bodies for approval. This has been done in 3 stages to enable proper reflection and consideration of the details.</td>
</tr>
<tr>
<td>• Foundation Trust Membership Audience (32,000)</td>
<td></td>
</tr>
<tr>
<td>• Lay/ Patient Reference Groups established in both CCGs to provide ongoing scrutiny of the developments</td>
<td></td>
</tr>
<tr>
<td>• The Community Hub Groups in each of the 8 communities also had at least 2 lay reps as members</td>
<td></td>
</tr>
<tr>
<td>• The Cross system reviews of the options have also involved lay reps</td>
<td></td>
</tr>
<tr>
<td>The feedback from each of the events and ongoing involvement has been crucial in informing and developing the proposals identified.</td>
<td></td>
</tr>
</tbody>
</table>

Ongoing patient and public engagement will be at the heart of concluding the proposals through the consultation exercise; the consultation plan will demonstrate how this will be achieved.
Equality groups

The 21C Programme has made a proactive commitment to considering the impact of any changes on the equality groups. Groups have been engaged and this will continue on an ongoing basis.

A proactive commitment

The 21C Programme has made a proactive commitment that due regard will be given to how any changes will affect protected/vulnerable groups. This will include identification of any negative implications and how they can be mitigated.

Following an assessment of the equality groups - namely age, sex, disability, race, religion or belief, marital status, sexual orientation, pregnancy & maternity, gender reassignment/ transgender. We believe that given the nature of changes to service provision being proposed, we need to consider the protected characteristics of age and disability most closely.

We are well underway in our conversations with a variety of typically hard to reach groups across the communities, and have been working closely with the voluntary and community sector to access service users and residents who are often seldom heard.

We have held a number of focussed sessions with these groups including:

• The Black and Ethnic Minority Forum
• MASH – Mental Health Group
• Bolsover 50+ Forum
• Sunncroft Older People’s Group
• Chesterfield 50+ Forum
• Chesterfield Deaf Club
• Chesterfield Thursday Rendezvous Club
• Fairfield Older Person’s Club

The full engagement report can be found in the appendix, together with an initial Equality Impact Assessment that was undertaken to start to understand the potential negative implications of the proposed changes and how they could be mitigated.

Moving forward

As part of the 21C Programme’s forthcoming conversations and formal consultation, additional work will be undertaken to engage and consult a wider representation of groups and communities that are seen as seldom heard or marginalised. This will be done in line with the protected characteristics in Equalities Act 2010, and the demographic of North Derbyshire.

This will continue to ensure that the voices of those groups who do not traditionally engage are able to receive information, and have the opportunity to debate and discuss how any potential changes may affect them.
Understanding what it would take to deliver the proposed changes

This section describes preliminary consideration of ‘what it would take’ to deliver the proposed changes:

1) Risk assessment (including quality impact)
2) Workforce planning and development
3) Commissioning, contracting and finance
4) Implementation principles, timeline and ‘what it would take’
5) Consultation messages and consultation planning
Risks and mitigations – 21C Joined Up Care Programme

Across the 21C Programme a consistent approach to measuring, managing and reporting risks is applied. In addition, the Community Hubs Working Group has given initial consideration to the implementation risks associated with the proposals set out in the PCBC

21C Programme risk management

A consistent approach to risk management is used across the 21C Programme. Central to this is a risk register which outlines the risks, the level of impact and mitigations and named accountable officers. The register is overseen and reported to the 21C Plan Delivery Group and maintained by the Programme Management Office. This ensures outline principles of measuring, managing and reporting risk are maintained.

Risks are considered in two ways:

- Programme (Strategic) Risks – these are managed by the sponsors of the project, namely the Chief Officers of NHS North Derbyshire CCG and Hardwick CCG on behalf of the 21C #JoinedUpCare programme. Risks are political, economic, financial, regulatory (macro level) which may be external to the programme and can therefore may be escalated to the CCG Governing Bodies and Provider Boards.

- Workstream/Project Risks – these are managed and reported by the worksteam leads to the 21C #JoinedUpCare Plan Delivery Group. Programme risks are classified as those that will directly affect the successful delivery of the 21C #JoinedUpCare work-streams.

The maintenance of the programme risk register ensures that risks are identified, owners of the risk are identified, risks are evaluated for likelihood and impact and risks are responded to through the appropriate implementation of mitigating actions. Risks are scored based on their likelihood and impact. Risks are scored as they are identified (pre mitigation) and then given a score based on the implementation of the mitigating actions identified (an overview of the high-medium programme risks is provided in the appendix).

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>4</th>
<th>4</th>
<th>8</th>
<th>12</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Community Hubs Pre-Consultation Business Case Risks and Mitigations

In addition to the risks and mitigations identified and managed through the overall programme, the Community Hubs Working group has compiled an initial set of risks associated with the implementation of the proposals set out in the pre-consultation business case. These risks have been identified through a number of means:

- Discussions with clinical leads and the Clinical and Professional Reference Group (CPRG)
- Completion of a Quality Impact Assessment (see appendix for full report)
- Consideration of workforce challenges by the Workforce Working Group
- Development of a high level implementation plan
- Development of the contracting and finance approach

The same outline principles of measuring, managing and reporting risk that are applied at a programme level have been applied.

Risks are presented against each of the areas where proposals for change are presented and categorised as:

- Clinical
- HR/Workforce
- Operational
- Corporate

This initial assessment of risk is provided in the appendix, and will be continually reviewed, monitored and adjusted as plans are refined and developed further following the consultation.

North Derbyshire 21CJoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
Risks and mitigations – Surge and escalation planning

The North Derbyshire Health and Care system has a well-established and embedded approach to system resilience, and surge and escalation planning. Consideration has been given to the adjustments required to the current approach to align it to the proposed new models of care.

Context

An agreed system wide Urgent Care Escalation and De-escalation Plan is in place that covers the county of Derbyshire and has agreement and signoff of all providers (Health, Social and Voluntary) and commissioners, within the plan are agreed escalation triggers and actions with corresponding escalation levels.

The North Unit of Planning as a network have a mature and positive relationship as a system which formally meet on a monthly basis as a System Resilience Group (SRG), these positive working relationships have been established over a long period of time where trust and respect have been gained amongst providers and commissioners. During times of pressure such as the winter period more frequent discussions take place and this is evidenced by the weekly tele-conference call where a senior executive representative from all providers and commissioners joins the conference call chaired by the SRG Chairman. These calls are in place to unblock and resolve any issues that are apparent using a multi-agency solution using a constructive and supportive approach. This includes any immediate bedding capacity issues within CRH, the community setting or in DCC Care Homes. Where pressure and problems exists agencies work together to resolve any issues and if needed an urgent SRG tele-conference is set up and joined by executive representatives from commissioners and providers.

Proposed adjustments to current approach if proposed new care models for community rehabilitation and OPMH beds are introduced

The reduction in community rehabilitation and OPMH beds provides an opportunity for more patients to be cared for and nursed within their own home. Such a reduction in beds will see staffing levels increased within community settings covering all disciplines and agencies to provide wraparound care for patients in their own home, this includes both health and social care. The staffing levels within the community have the ability to flex up and flex down dependent upon the current pressures being felt across the system, this flexibility will support the need to provide more care to patients within their own home.

current approach to surge and escalation planning are proposed to ensure the health and care system is still able to continue to deliver high quality care at times of significant escalation (e.g. extreme winter weather and flu epidemic):

• A cultural change to the whole system, which would see escalation and system resilience embedded into the culture and operating ethos of each of the eight communities rather than the current escalation processes that is managed by a very few senior leaders across health and care commissioners and providers. This will require:
  • The development and agreement of a number of operating principles at community level
  • A local community based approach to developing System Resilience plans
  • An approach that is summed up by ‘think North Derbyshire act local’ happening at Community level
  • Consistent, ongoing ‘set-piece’ dialogues with each community to embed System Resilience as a local level collective responsibility.

• Standard community team staffing levels will be based on average activity levels through the year, however there will be clear procedures in place to flex up during times of increased demand. When surges in activity are experienced (or planned staff numbers fall substantially) increasing capacity in the community teams (as opposed to increasing bed capacity) will be the priority. This will be done through a combination of the following actions depending on severity:
  • Alert senior managers / heads of services
  • Review staffing across all community teams and reallocate work as necessary
  • Review staffing for the whole week and identify Bank staff availability
  • Assessment of staffing levels on a regular basis
Workforce Planning – context and principles

Workforce development is the key part of the implementation of the proposed changes. We already have a successful track record of delivering a transition of care from hospital (ward) based settings to community based delivery. We have defined a set of principles to direct workforce development...

Overview and context

To enable the delivery of high quality care, within or close to where people live, the proposed changes require us to develop our workforce in a number of ways:

i. Staff will need to work in multifunctional community based teams, supporting people and their carers to meet their social, mental and physical care needs; this will require more joined up working both across functional disciplines and across organisational boundaries.

ii. Staff who currently work within a hospital setting, where they travel to a place of work, will need to work within communities; often traveling to support people in their own homes. The will require new skills and behaviours. Also, access to, and support from, senior clinical and professional team members.

iii. The proposed services require (i) greater access to physiotherapy and occupational therapy expertise; (ii) more community based care support workers. These will require a combination of development, recruitment, retention and working differently within teams.

iv. Working more effectively across organisation boundaries (health and social care) will require processes of employment and training which are collaborative to ensure ease of redeployment and training for staff regardless of which Organisations employs them.

We already have a successful track record of delivering a transition of care from hospital (ward) based settings to community based delivery. The proposed changes are the next ‘step change’ – placing increased emphasis on joined up team working.

This section:

• Outlines the principles which direct workforce planning;

• Draws together the overall scale of change from the combined proposals and what this means for staff groups;

• Describes why we are confident we changes can be delivered and how we are approaching the workforce planning and development.

Principles

Workforce development is the key part of the implementation of the proposed changes. As such, most of the principles are shared with those directing the implementation planning. Workforce development will follow these principles:

• Changes will be focused on delivering more effective joined up care and will be directed by local situation and needs;

• Staff will be retained, retrained and redeployed wherever possible;

• Workforce changes will be co-ordinated on a cross system basis to ensure fair and equitable opportunities for all staff impacted;

• Plans will be necessarily adapted as needs and situations change;

• Implementation plans and progress will be shared with staff and the public after the outcome of consultation;

• The programme will endeavour at all times to minimise the transformation costs and timescales associated with the change;
Workforce Planning – overall scale of change

Whilst the overall scale of the changes is significant, we are confident they are achievable over the period of the programme because we have a strong track in delivering workforce transformation...

Combined impact of the proposed changes

<table>
<thead>
<tr>
<th></th>
<th>Community bedded care</th>
<th>Specialist OPMH</th>
<th>OPMH Day Unit Services</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>20 fewer registered</td>
<td>15 fewer registered</td>
<td>5 fewer HCA</td>
<td>35 fewer registered</td>
</tr>
<tr>
<td></td>
<td>33 fewer HCA</td>
<td>2 fewer HCA</td>
<td></td>
<td>40 fewer HCA</td>
</tr>
<tr>
<td>Therapists</td>
<td>OT +10; physio +20;</td>
<td>OT +2.6; physio +0.6; therapy support +0.4</td>
<td>OT -4.7; therapy support -3.7</td>
<td>30 more therapists</td>
</tr>
<tr>
<td></td>
<td>therapy support +4.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social care</td>
<td>care workers +95</td>
<td>care workers +7</td>
<td>Additional respite care provision (staffing TBD)</td>
<td>102 more care workers</td>
</tr>
<tr>
<td></td>
<td>(40 IC beds; 55 ICS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin and ancillary</td>
<td>admin – 4.2, ancillary -5.4</td>
<td>housekeepers -2.7</td>
<td>Admin -1.5</td>
<td>12 fewer</td>
</tr>
<tr>
<td>Additional skill in the community team</td>
<td>ANP / ACP +7; dementia support +7.5, geriatrician +1.1, pharmacist +1</td>
<td>clinical leads +2, psychologist +0.4, psychiatrist +0.4</td>
<td></td>
<td>11 more</td>
</tr>
</tbody>
</table>

Within each of the proposals, previously described in this PCBC, is a description of the key workforce changes.

For the proposals related to specialist OPMH, dementia day unit and community bedded care, there are more specific team changes proposed. The scale of the net impact of these changes is summarised in the table above.

Whilst the overall scale of these changes is significant, we are confident they are achievable over the period of the programme (2-3 years) because we have a strong track in delivering workforce transformation:

* Reductions in nursing workforce – over the past three years we have successfully managed circa 150 redeployment’s and retraining of qualified nurses.
  * We have a track record of redeployment and retraining from inpatient settings to work across the county in community settings
  * We have sufficient turnover in our nursing workforce to provide opportunities

* We have a plan to develop specialist staff to ACP working through the Derbyshire wide academy where it takes 18 months to educate this workforce
* The proposed requirement for the number of physiotherapist and OT’s will be met by the work we are doing with HEE on commissions, accelerated recruitment practices and developing a attractive rotational programme which will attract newly qualified ambitious people to Derbyshire
* The demand for care workers is a significant challenge to ensuring the success of our new care models and in response we will work in partnership across Health and Social care to develop a Care Academy to attract staff of all ages to the caring workforce which will support them with pathways of development and accreditation

Further details of our workforce development plans are provided in this section.
Workforce Planning – workforce planning and development

What we are already doing...

Engaging our staff:
• Operational managers and Service Commissioners have engaged the existing workforce advising of the direction of travel in North Derbyshire linked to the strategic programme of change around 21st Century Care.

Aligning policies and processes across organisation boundaries:
• Across Health and Social care Organisations in Derbyshire work has commenced to align workforce policies and processes such that this enables workforce transformation.
• Regional work has also seen change to recruitment processes such that we are reducing time to recruit.
• Across the East Midlands all Healthcare Organisations (Streamlining programme) have undertaken work to align their education and training position so that we can easily understand what statutory training all staff have undertaken and when they have done this. This enables efficiency when staff work across a geographical location for different organisations.
• DCHS is also a national pilot site for the next iteration of Electronic Staff Record which again will enhance our ability to share and inform the learning needs of staff and share workforce intelligence across partners.

Workforce planning:
• We have worked to align service workforce and financial information to support the development of the PCBC. This has developed a sense of the high level workforce implications and provides the basis of our future plan of workforce transformation.
• To date we have largely planned our workforce by separate Organisations with limited engagement or discussion with colleagues in Primary Care, as model of services change we will need to have innovative workforce planning processes to maximise our understanding of not only what the current workforce resource is but also how we work collectively to plan our future requirements, developing innovative recruitment solutions.
• Across Derbyshire we have commenced using the Strategic Workforce Planning and Evaluation approach (SWIPE) initially for Frail Elderly. This approach demands collaborative approach using the population needs approach as the way of understanding what may be required to meet the future service delivery; it has been widely accepted with all Health and Social care Partners engaging in this work.

Training and development:
• Across Derbyshire we have developed a Derbyshire wide workforce plan (DWWFP) which has helped inform the commissioning of education and training, in 2015/16 Health Education England (HEE) working across the East Midlands have provided circa £1.5m to address education and training.
• In Derbyshire we have specifically targeted this funding to grow our supply of Advanced Clinical Practitioners; work is in place to develop a Derbyshire wide ‘academy’ which will support the education, training and supervision requirements of this workforce.
Workforce Planning – workforce planning and development

What we are planning to do...

Engaging our staff:

• The risks associated with the scale of change are many and some of which are beyond control as individual staff will make personal decision about their future employment. However as a strategic partnership, to mitigate this risk we have worked to engage our staff, outline the direction of travel for all Health and Social care services, agreed in principle to look to redeploy and develop our existing workforce and worked across Organisations as outlined to align workforce processes so that transformation is enabled.

• During 2016 we will need to continue to communicate with staff, Professional and Staff side partners and with the Public to continue to advise that the scale of workforce change does not equate to reduction in the existing clinical workforce rather it is a redeployment of this workforce with changes roles and changing places of where services are delivered; noting that the risk to delivery is the nature of a large geographical patch where some of our workforce may not have access to transport or be able to drive.

Workforce planning:

• In 2016 what is now required is a specific workforce plan for 21st Century Care which aligns to the overarching DWWFP and provides a detailed summary of actions required to deliver the workforce transformation.

Recruitment:

• Further the risks to delivery of this transformation are linked to national and local workforce supply issues; whilst across Partners we can work to develop recruitment campaigns there remains a risk that for General Practitioners (GP’s), Registered Nurses (RGN/RMN/RNLD) and AHP (Occupational Therapists/Physiotherapists/Speech & Language Therapists) we will be challenged to recruit and retain the required workforce.

• Having a continuous supply of support workforce to deliver direct care in Health and Social care settings also provides challenge and risk to delivery of services where there is increased home based care. Work is required to understand the current supply in the Private, Voluntary and Independent sector (PVI) and to consider what we could collaboratively undertake to address this workforce challenge.

Training and development:

• With this in mind we have commenced the development of ACP supply, noting that the training is between 18 months and 3 years, with a requirement to commission posts for these trainees to move into on completion of their education.

• Culturally we are asking our workforce to move towards a service which promotes independence and self-care; moving away from delivering to facilitating both the individual, their family, their carers and the wider community. We have commenced the scoping of Organisational Development needs in 2015 and the output of this will inform the options required in every area to support such change.
Commissioning, contracting and finance arrangements

Commissioners and Providers have worked together to understand the overall financial scale of the proposed changes and to agree in principle how they would be able to support the necessary investments and how to share the potential benefits of the proposed changes...

Background

In 2014/15 initial work by the North Derbyshire Unit of Planning, as part of the 21st Century plan forecast that, if the current model of delivery is maintained to meet future demand the system will face a financial gap of c. £150m.

The plan recognised that it is no longer realistic or credible to deliver efficiencies as we have done in the past, with CCGs concentrating on their QIPP and providers on their CIP, independent of each other. This plan proposes a cross system approach to delivering the required change that will be delivered through multi organisational service transformation.

We must remain cognisant that commissioners and providers still have duties to meet their own financial obligations and that they may be able to make efficiencies outside the scope of the 21st Century Transformation Programme that they retain to meet these obligations. And, it is clear that the health community is moving towards a Derbyshire footprint and has to produce a joint 5 year Sustainability and Transformation Plan (STP) Plan in 2016 that will potentially have a single system-wide control total in the near future.

At the 21st Century Programme Board in June 2014, all Commissioners and Providers agreed that the plan provides a basis to inform priorities and made clear the scale of actions required. Commitment was also given to continuing to work together with our population, to plan and deliver the changes.

In September 2014, ‘Boards’ received a summary setting out the direction of our Five-Year Plan and the status of work to deliver that plan.

In summary it stated that:

• Commissioners and providers are committed to the aims and principles detailed within the Plan.
• Significant progress has been made to identify priorities, establish leadership and determine the overall approach to developing and delivering joined up care.
• The approach provides significant challenges to existing organisation and role boundaries.
• All organisations recognise that changes need to be co-ordinated and implemented cross system. That all organisations must be prepared to actively manage the uncertainty it presents.
• There are a number of questions that need to be addressed, to provide confidence and assurance that the system is sufficiently ready to manage the changes.

Delivering the plan

North Derbyshire commissioners and providers are already starting to experience a significant increase in financial risk, but delaying implementation of this plan will only adversely impact upon the financial sustainability of all providers and commissioners in North Derbyshire, so a collective response is required. It is imperative that any changes made do not adversely affect the current system and the individual organisations within it. The plan is all about integrated care and, therefore, working together with existing providers.

System leaders recognise that managing this transition will be a complex and often ambiguous challenge. They should not underestimate the scale of change, but nor do they yet know all of what it will take to deliver. Hence, one of the underlying principles is ‘learning by doing’ and we must recognise that this means commissioners and providers not having ‘complete and definitive’ answers to all these questions. However this should not be a barrier to progress and in some cases, there will be no single ‘right answer’.

We have already made a number of changes to care across North Derbyshire. The aim now is to learn from these and implement change at a scale and pace which enables us to address the changing needs of our population.

The key principles of the approach taken so far are based on cross functional teams (health, social care and voluntary organisations) providing integrated care, working in geographic communities. These are directed by the ongoing care needs of the people to be supported – understanding that not ‘one size fits all’.

Whilst working through the implications of this approach, system leaders are recognising that this approach necessarily provides significant challenges to existing organisation and role boundaries. Again these must not be a barrier to progress and all organisations must remain committed to the direction of travel as success is dependent on a co-ordinated cross system approach.

Continued...
Commissioning, contracting and finance arrangements

Commissioners and Providers have worked together to understand the overall financial scale of the proposed changes and to agree in principle how they would be able to support the necessary investments and how to share the potential benefits of the proposed changes...

The Agreed Principles

1. To deliver the change required in 2016/2017 there needs to be a common understanding of the way we would contract for the proposed changes. The commissioners are committed to contracting in a way that ensures North Derbyshire continues to have sustainable Acute, Community and Mental Health services for our patients.

2. Commissioners are required to act transparently and proportionately, in a non-discriminatory way and consider all issues when commissioning any new services.

3. And, Commissioners have the ability to adjust the contracts held with providers to meet the needs of the population and they will continue to do this in order to deliver the necessary changes to existing services as part of 21C. Building on the work done in the last 2-3 years (e.g. investment in community teams) and using the expertise of our existing providers, we will commission services to deliver the necessary system transformation.

4. The whole system will then share in the intended financial efficiency gains, whilst striving to maintain financial balance across the STP footprint.

5. To enable the changes, we are looking to create a Transformation Fund that both commissioners and providers will contribute towards that will invest money within the existing system to fund potential parallel running costs and pump prime genuine system-wide transformation.

6. The Sustainability and Transformation Plan (STP) work currently underway across Derbyshire will look at how the transformation fund is established and how funds will be made available.

7. It is recognised there can be no ‘one size fits all’ approach to apportioning the efficiency gains of the different transformational business cases; these will need to be agreed on a case by case basis.

8. Potential efficiency gains can be categorised in several ways and the level of contribution made to the Transformation Fund must also be considered when apportioning the efficiency gains.

Summary

The general principles of the 21st Century plan were agreed several years ago and the North Derbyshire health system is moving into a critical year in terms of the financial stability of the organisations within it. It is important that the pace of system wide change is increased in order that the individual organisations within the North Derbyshire health system remain sustainable. To best achieve this aim, early agreement of the general principles to be adopted for 2016/2017 will enable organisations to be ready to meet the challenges ahead.
Commissioning, contracting and finance arrangements

Commissioners and Providers have worked together to understand the overall financial scale of the proposed changes, the necessary investments and the potential benefits of the proposed changes...

Summary

The summary table to the right shows the combined impact of the proposed changes.

It highlights the overall benefits by year in comparison to the projected costs and in comparison to the current baseline.

In addition, it shows the year to year phasing including where in the first year of implementation, there would need to be a combined investment of c. £1.6m. Note, further more detailed consideration of the phasing suggest that this initial investment maybe of the order of £1m.

The table above shows that overall, the proposed set of changes would enable the system to contain a 4% per annum (c.21% overall) increase in demand within the existing cost envelope.

In addition, the system could make a c.£900k per annum saving from site rationalisation.

And, has the opportunity to further save £2.3m per annum by tackling the remaining ‘stranded overhead’ costs (which is made up of sites c.£1.1m and corporate overhead c.£1.2m).

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Total service costs (based on £11.8m beds)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total stranded costs</td>
<td>22,391</td>
<td>19,851</td>
<td>18,961</td>
<td>18,585</td>
<td>18,889</td>
<td>19,201</td>
</tr>
<tr>
<td>Sub-total</td>
<td>22,391</td>
<td>24,016</td>
<td>22,458</td>
<td>21,806</td>
<td>22,091</td>
<td>22,587</td>
</tr>
<tr>
<td>Site rationalise</td>
<td>-</td>
<td>-400</td>
<td>-670</td>
<td>-890</td>
<td>-890</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>22,391</td>
<td>24,016</td>
<td>22,458</td>
<td>21,806</td>
<td>22,091</td>
<td>22,587</td>
</tr>
<tr>
<td>Remaining stranded costs</td>
<td>4,165</td>
<td>3,048</td>
<td>2,551</td>
<td>2,134</td>
<td>2,297</td>
<td></td>
</tr>
</tbody>
</table>

---

**Dementia Day Unit Current service:**

- OPMH Dementia Day Units: 1,872, 1,946, 2,024, 2,105, 2,190
- Growth on baseline: 0, 79, 81, 84, 89
- Projected cost (same service): 1,872, 1,946, 2,024, 2,105, 2,190
- Projected cost (same service): 2,277

**Proposed service:**

- OPMH Dementia Day Units: 600
- (i) Organic assessment: 129, 134, 139, 145, 151
- (ii) UNWDD & CST: 230, 478, 497, 517, 538
- (iii) Carer support & respite: 100, 208, 216, 225, 234
- (iv) Functional illness: 129, 134, 139, 145, 151
- Total proposed service: 1,187, 954, 992, 1,032, 1,073
- Stranded other overheads, site costs: 600, 500, 400, 400, 400
- Total (incl. stranded costs): 1,787, 1,454, 1,392, 1,432, 1,473

**Dementia service current costs:**

- OPMH bedded care: 8,700, 9,048, 9,410, 9,786, 10,178
- Growth on baseline: 0, 348, 362, 376, 391, 407
- Projected cost (same service): 8,700, 9,048, 9,410, 9,786, 10,178, 10,585

**Proposed service:**

- (i) Specialist OPMH (Walton): 5,618
- (ii) Dementia Rapid Response Team: 416, 1,388
- (iii) Other existing direct OPMH ward costs: 2,000, 1,000, 0, 0, 0
- Total proposed service: 8,034, 8,206, 7,969, 8,051, 8,133
- Stranded Other overheads, site costs: 1,056, 1,056, 1,056, 1,056, 1,056
- Total (incl. stranded costs): 9,090, 9,262, 9,025, 9,107, 9,189

**Community bedded care current service:**

- Community bedded care: 13,424, 13,434, 13,961, 14,519, 15,100, 15,704
- Growth on baseline: 0, 537, 558, 581, 604, 628
- Projected cost (same service): 13,424, 13,961, 14,519, 15,100, 15,704, 16,331

**Proposed service:**

- (i) Specialist rehab beds: 0
- (ii) Local Intermediate Care beds: 1,696, 2,846, 2,882, 2,940, 2,989
- (iii) Community Integrated Care Service (CIS): 1,430, 2,888, 3,326, 3,460, 3,598
- (iv) Other existing direct bedded care costs: 7,503, 1,730, 0, 0, 0
- Total proposed service: 16,629, 15,801, 15,624, 15,806, 16,994
- Stranded Other overheads, site costs: 2,509, 1,942, 1,766, 1,749, 1,731
- Total (incl. stranded costs): 13,128, 13,742, 13,930, 13,555, 13,729

**Difference to projected costs:**

- £13,128, 13,742, 13,930, 13,555, 13,729

**Difference to revised 15/16 baseline (£11.819k):**

- £1,319, -77, -430, -264, -94

**Situation rationalisation:**

- Bolsover site costs (net saving): -450, -450, -450, -450, -450
- Newhoulme site costs (net saving): -220, -440, -440

**Total diff to projected costs:**

- -940, -3,945, -5,855, -6,867, -7,696

**Total diff to baselines:**

- 2,624, -383, -1,255, -1,188, -809
Implementation planning – context and principles

The particular proposals contained in this PCBC are subject to public consultation and as such they are still formative and may change. Consequently, specific and detailed implementation planning has not yet been completed. Nevertheless, there are a set of principles which would direct implementation planning and we have considered of ‘what it would take’ to deliver the changes...

Introduction and context

As previously described within this PCBC, the development of Community Hubs is a critical element of the North Derbyshire system plan to improve how care is provided for the people of North Derbyshire. Fundamentally, the aim of the whole system plan is to keep people:

- Safe & healthy – free from crisis and exacerbation.
- At home – out of social and health care beds.
- Independent – managing with minimum support.

... which will be founded on building strong, vibrant communities.

‘Community Hubs’ is also the name of the work stream which is co-ordinating the development of the hubs. Crucially, it will link with, and be dependent upon, other work to develop joined up care services.

The overall development of Community Hubs should be seen as a ‘progressive process’ that will evolve over the coming years as the needs and expectations of people develop; this is not just a one off ‘project’.

The particular proposals contained in this PCBC are subject to public consultation and as such they are still formative and may change. Consequently, specific and detailed implementation planning has not yet been completed. Nevertheless, the outline implementation plans contained within each of the proposal areas necessarily sets expectations for the pace of change.

This section:

- Outlines the principles which will direct implementation planning;
- Draws together and describes the overall timeline;
- Summarises ‘what it would take’ to deliver the changes;
- Frames the approach which will be taken to manage the implementation.

Principles

Implementation planning would follow these principles:

- Changes will be focused on delivering more effective joined up care and will be directed by local situation and needs;
- No site or service will be closed unless a clinically suitable alternative has been put in place;
- Staff will be retained, retrained and redeployed wherever possible;
- Workforce changes will be co-ordinated on a cross system basis to ensure fair and equitable opportunities for all staff impacted;
- Implementation plans and progress will be shared with staff and the public;
- The programme will endeavour at all times to minimise the transformation costs and timescales associated with the change;
Implementation planning – overall timeline

The figure below draws together and describes the overall timeline...

<table>
<thead>
<tr>
<th>Apr-16</th>
<th>Oct-16</th>
<th>Dec-17</th>
<th>Dec-18</th>
<th>Dec-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing development of Joined Up Care (e.g. ICS)</td>
<td>Public Consultation</td>
<td>Ongoing staff engagement and consultation</td>
<td>Ongoing public engagement within each community</td>
<td>Programme management</td>
</tr>
<tr>
<td>OPMH bedded care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Specialist OPMH bedded care (Walton)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dementia Rapid Response Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Existing OPMH bedded care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPMH day units</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Living Well With Dementia</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Older persons functional illness support</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>- Carer support and Respite</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Community beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Specialist Rehab Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Community Integrated Care Services (ICS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Local Intermediate Care Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Existing community bedded care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for people with learning disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Short Breaks (respite)</td>
<td></td>
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<tr>
<td>- Intensive Support Service</td>
<td></td>
<td></td>
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<tr>
<td>- In-patient Assessment and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Community LD teams &amp; Provider development</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other services / site rationalisation</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>- Local provision of alternative outpatient clinics</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Other local service bases</td>
<td></td>
<td></td>
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<tr>
<td>Community Hub / Network development</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL
Implementation planning – outline plan OPMH

The tables below summarise ‘what it would take’ to deliver the changes...

<table>
<thead>
<tr>
<th>Proposed service activity</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Specialist OPMH (Walton)</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>(ii) Dementia Rapid Response Team</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>(iii) Other OPMH wards</td>
<td>40%</td>
<td>30%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total proposed service</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Notes:
- <<< Establish Walton as the centre of excellence for specialist OPMH dementia care
- <<< Implement DRRT 1; redeploy expertise from inpatient services to community
- <<< Ramp down bed based capacity in Newholme and Cavendish

What it would take to implement the proposed changes...

Specialist OPMH (Walton)

**Team / workforce:**
- Review ward team definition and how it will work with DRRT, acute frailty, ICS and primary care
- Development of ward team

**Processes:**
- Experience demonstrates that decreased beds will increase the acuity of individuals using those beds – this means that we will need to ensure that staffing establishments are sufficient in terms of both capacity and skill-mix
- Governance: clear definition of clinical governance responsibilities

Dementia Rapid Response Team

**Team / workforce:**
- Workforce development plan - incl. redeployment of existing ward based staff
- Recruit / develop new team roles therapists (OT, PT), clinical lead, psychiatrist, etc.
- Develop culture of integrated teams (health, social, voluntary, carers)

**Processes:**
- Definition / specification: specific function/how it will work with CMHT/Adult Care/ICS/quality standards/governance etc
- How it will work with Intermediate Care, and Community Integrated Care services
- Finance: agree transitional funding

Other OPMH wards

**Team / workforce:**
- Staff consultation – management of change
- Workforce planning and development - redeploy and develop existing staff

**Processes:**
- Plan and manage transitional arrangements (double running, maintain quality of care)
- Finance: agree transitional funding

**Facilities:**
- Plan and manage ramp down of existing capacity
- As appropriate, redevelop ward space as part of community hub / network development
- Link with proposed site rationalisation
## Implementation planning – outline plan OPMH day units

The tables below summarise ‘what it would take’ to deliver the changes...

### What it would take to implement the proposed changes...

<table>
<thead>
<tr>
<th>Living Well With Dementia</th>
<th>Olders persons functional illness support</th>
<th>Carer support and Respite</th>
<th>Existing day unit services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team / workforce:</strong></td>
<td><strong>Team / workforce:</strong></td>
<td><strong>Team / workforce:</strong></td>
<td><strong>Team / workforce:</strong></td>
</tr>
<tr>
<td>• Expand / develop existing LWWD programme incl. redeployment of day unit staff</td>
<td>• Develop / extend Neighbourhood Mental Health Team</td>
<td>• Workforce development with NHS staff to ensure they are carer aware and also aware of what support is available for carers</td>
<td>• Staff consultation – management of change</td>
</tr>
<tr>
<td>• Develop culture of integrated teams (health, social, voluntary, carers)</td>
<td>• Develop team to work more collaboratively within communities (with ICS, primary care), initially providing the treatment element of care and then in local social groups.</td>
<td></td>
<td>• Workforce planning and development - redeploy and develop existing staff</td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
<td><strong>Processes:</strong></td>
<td><strong>Processes:</strong></td>
<td><strong>Processes:</strong></td>
</tr>
<tr>
<td>• Establish transition plan to reduce episodes of all day attendance to group/treatment specific attendance</td>
<td>• Stakeholder engagement to identify what social capital exists across communities and opportunities for collaboration i.e. health and social care along with voluntary sector organisations, community support/activities groups, neighbourhood support capacity e.g. local shops, businesses etc..</td>
<td>• Identify which individuals have carers</td>
<td>• Plan and manage transitional arrangements (double running, maintain quality of care)</td>
</tr>
<tr>
<td>• Progress current fledgling group delivery in all sectors/GCs</td>
<td>• Identify the current formal health and social care services that might be extended in their current remits to be able to support older people with functional illness (e.g. DCHS provided – 'Live Life Better Derbyshire' can work with mental health patients so long as their illness is controlled by medication).</td>
<td>• Ensure carers assessment and support embedded in all interventions or contacts</td>
<td>• Finance: agree any transitional funding</td>
</tr>
<tr>
<td>• Review and manage existing patient group with robust onward plans of care</td>
<td>• Identify the current formal health and social care services that might be extended in their current remits to be able to support older people with functional illness (e.g. DCHS provided – 'Live Life Better Derbyshire' can work with mental health patients so long as their illness is controlled by medication).</td>
<td>• Commission from Adult Care specialist dementia home care hours or Adult Care day services, to be funded through personal health budgets or pre – investment in the services</td>
<td>• Manage the message -public consultation; clarity around the descriptions of the new service models will provide assurance of improved ways of meeting service user’s health and social care needs as well as better access to much valued services going forward</td>
</tr>
<tr>
<td>• Establish robust link and joint working with integrated care teams, particularly CMHTs</td>
<td>• Manage the message -public consultation; clarity around the descriptions of the new service models will provide assurance of improved ways of meeting service user’s health and social care needs as well as better access to much valued services going forward</td>
<td>• Align with LWWD programme</td>
<td><strong>Facilities:</strong></td>
</tr>
<tr>
<td><strong>Building outreach model for the LWWD &amp; Cognitive Stimulation Therapy programmes:</strong></td>
<td><strong>Facilities:</strong></td>
<td>• Align with CST programme</td>
<td>• Plan and manage ramp down of existing capacity</td>
</tr>
<tr>
<td>• Community dementia pathway definition</td>
<td>• Offer carer respite through specialist dementia home care or Adult Care day services</td>
<td></td>
<td>• As appropriate, redevelop space as part of community hub / network development</td>
</tr>
<tr>
<td>• Identify opportunities for collaboration</td>
<td>• Explore the opportunity to deliver the programmes within DCC Community Care Centres such as Meadow View etc.</td>
<td></td>
<td>• Link with proposed site rationalisation</td>
</tr>
<tr>
<td>• Promote service with 'referrers' – MAS clinics, early diagnosis in Primary Care, ICTs, CMHTs</td>
<td>• Alternatively some people may prefer to have their respite provided in their own homes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Implementation planning – outline plan Community Bedded Care

The tables below summarise ‘what it would take’ to deliver the changes...

<table>
<thead>
<tr>
<th>Proposed service activity:</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Specialist rehab beds</td>
<td>0%</td>
<td>0%</td>
<td>16%</td>
<td>21%</td>
<td>21%</td>
<td>&lt;&lt;&lt; Implement in year 2 when ICS &amp; intermediate care have been further developed</td>
</tr>
<tr>
<td>(ii) Local intermediate care beds</td>
<td>16%</td>
<td>18%</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
<td>&lt;&lt;&lt; Realigned and developed as additional ICS is developed</td>
</tr>
<tr>
<td>(iii) Community Integrated Care Service (ICS)</td>
<td>0%</td>
<td>18%</td>
<td>45%</td>
<td>50%</td>
<td>50%</td>
<td>&lt;&lt;&lt; Building on existing ICS development, further capacity ramped up during year 1</td>
</tr>
<tr>
<td>(iv) Other existing direct bedded care</td>
<td>84%</td>
<td>64%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>&lt;&lt;&lt; Other existing ward based capacity realigned and/or decommissioned</td>
</tr>
<tr>
<td>Total proposed service</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>&lt;&lt;&lt; Changes implemented by the end of year 2</td>
</tr>
</tbody>
</table>

What it would take to implement the proposed changes...

Specialist Rehab beds

**Team / workforce:**
- Ward team definition and how it will work with acute frailty, stroke, ICS and primary care
- Redeployment and development of ward teams (East & West)

**Processes:**
- Definition / commissioning specification: specific function / how it will work within step down (D2AM)
- Governance: clear definition of clinical governance responsibilities

**Facilities:**
- Business case for capital build (site adaptation)
- Build ward facility

Community Integrated Care Service (ICS)

**Team / workforce:**
- Expand / develop existing ICS teams incl. redeployment of community hospital staff
- Recruit / develop therapists (OT, PT, SALT, dietetics), ACP, etc.
- Develop culture of integrated teams (health, social, voluntary, carers)

**Processes:**
- Single assessment / single access
- Integrate D2AM
- Information: sharing (IG and systems)
- Governance: clear definition of clinical governance responsibilities
- Finance: agree transitional funding

Local Intermediate Care beds

**Team / workforce:**
- Develop team working – care centres with ICS in-reach
- Local Primary Care integration

**Processes:**
- Definition / commissioning specification: specific function, quality standards, governance, etc.
- Information: sharing (IG and systems)
- Governance: clear definition of clinical governance responsibilities
- Quality assurance – to ensure local IC beds consistently meet standards

**Facilities:**
- Commission local intermediate care beds to rebalance existing capacity and match local community needs

Other existing bedded care

**Team / workforce:**
- Staff consultation – management of change
- Workforce planning and development - redeploy and develop existing staff

**Processes:**
- Plan and manage transitional arrangements (double running, maintain quality of care)
- Finance: agree transitional funding

**Facilities:**
- Plan and manage ramp down of existing capacity
- As appropriate, redevelop ward space as part of community hub / network development
- Link with proposed site rationalisation

North Derbyshire 21C JoinedUpCare - Community Hubs
Pre Consultation Business Case – Stage 4 FINAL

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Implementation planning – outline plan Services for people with Learning Disabilities

The tables below summarise ‘what it would take’ to deliver the changes...

The reduction in acute assessment and treatment beds will pave the way for transfer of resources to support the development of the unified community service offer.

In addition, by providing a fair and equitable alternative personal offer to people who are using short breaks (respite) would lead to freeing up of resources locked into buildings and inflexible care models. Reinvestment of these resources will further support the 7 day unified community service model.

What it would take to implement the proposed changes...

<table>
<thead>
<tr>
<th>Short breaks (respite)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team / workforce:</strong></td>
</tr>
<tr>
<td>Consultation with current staff</td>
</tr>
<tr>
<td>Train and support existing staff teams to deliver new care pathways; redeploy existing staff wherever possible.</td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
</tr>
<tr>
<td>Prepare for effective person centred engagement</td>
</tr>
<tr>
<td>Establish alternative short break menu of options</td>
</tr>
<tr>
<td>Rolling programme of personal reviews</td>
</tr>
<tr>
<td>Rolling phased transition from NHS inpatient short breaks to implementation of alternative short breaks (respite)</td>
</tr>
<tr>
<td><strong>Facilities:</strong></td>
</tr>
<tr>
<td>Market management, signalling the need for bed based and alternatives to bed based solutions</td>
</tr>
<tr>
<td>Joint rationalisation of existing estate and decision regarding future viability.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensive support service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team / workforce:</strong></td>
</tr>
<tr>
<td>Recruitment to develop a 7 day multi-disciplinary intensive support team</td>
</tr>
<tr>
<td>Training and development of new philosophy, culture and approach</td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
</tr>
<tr>
<td>Evaluate this approach at 6 month intervals in the first year.</td>
</tr>
<tr>
<td>Monitor admission /avoidance to hospital beds and maintenance of support in peoples own home</td>
</tr>
<tr>
<td>Revised service specifications in line with new national and local model of care.</td>
</tr>
<tr>
<td><strong>Facilities:</strong></td>
</tr>
<tr>
<td>Office base for expanding the team and alignment with community hubs and existing Community LD teams</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In-patient assessment and treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team / workforce:</strong></td>
</tr>
<tr>
<td>Continue with access to 6 in-patient beds for 4-6 months post start date of the 7 day ISS</td>
</tr>
<tr>
<td>Workforce planning and development of a management of change programme</td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
</tr>
<tr>
<td>Review intelligence gathered from monitoring in-patient bed usage alongside the developing ISS model to determine local requirements for A&amp;T beds</td>
</tr>
<tr>
<td>Revise service specification</td>
</tr>
<tr>
<td><strong>Facilities:</strong></td>
</tr>
<tr>
<td>Conduct a joint rationalisation of all available community bed based accommodation</td>
</tr>
<tr>
<td>Adjust the number of LD in-patient beds and source alternative access to community accommodation for when people cannot be supported at home</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community LD teams</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team / workforce:</strong></td>
</tr>
<tr>
<td>Strengthen the therapy composition of the current teams.</td>
</tr>
<tr>
<td>Training and development of required skills for future proofing of new pathways.</td>
</tr>
<tr>
<td>Targeted recruitment to deliver skill mix and expertise required for the future model.</td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
</tr>
<tr>
<td>Revise service specification.</td>
</tr>
<tr>
<td><strong>Facilities:</strong></td>
</tr>
<tr>
<td>Team bases in existence.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team / workforce:</strong></td>
</tr>
<tr>
<td>Improve on the local market of providers, skills and expertise in supporting those with the most complex needs.</td>
</tr>
<tr>
<td>Develop collaborative relationships across all provider sectors in Derbyshire to effect the cultural shift required to achieve the new service model, sustain skills and expertise and resilience in local providers.</td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
</tr>
<tr>
<td>Develop a programme of market development in line with LA market position statements and awareness of gaps and deficiencies</td>
</tr>
<tr>
<td><strong>Facilities:</strong></td>
</tr>
<tr>
<td>Map local housing and accommodation</td>
</tr>
</tbody>
</table>
Implementation planning – outline plan: other services / site rationalisation

The tables below summarise ‘what it would take’ to deliver the changes...

What it would take to implement the proposed changes...

Local provision of outpatient clinics
• Bolsover: Understand site opportunities from which to deliver local outpatient services including established local community provision (Welbeck Road, Shirebrook Health Centre, Springs Health Centre (Clowne))
• Bakewell: Understand site opportunities from which to deliver local outpatient services; liaise with NHSPS as owner of the building
• Work with council to consider opportunities to re-provide services in partnership?
• Plan local staff and public engagement
• Bakewell: alternative site options evaluation in liaison with partner organisations
• Develop Business Case for any new site programme (development and disposal)
• Plan for capital & revenue implications & building procurement options

Provision of local service team bases
• Understand necessary team bases required (currently provided at Bolsover & Bakewell)
• Identify alternative location options
• Option evaluation
• Plan changes including any estate / facility development

Ramp down of redundant sites

Team / workforce:
• Staff consultation – management of change
• Workforce planning and development - redeploy and develop existing staff
• Relocate ‘corporate’ bases

Processes:
• Plan site facility changes at Bolsover and Newholme inline with proposed community service development
• Work with council partners to consider how to re-develop the sites
Implementation planning – co-ordinating and enabling the delivery of the changes

The tables below summarise ‘what it would take’ to deliver the changes...

Approach
Following public consultation and approval at the various commissioning and provider bodies, final proposals would be agreed.
The 21C Plan Delivery Group (made up of the Chief Officers of all the provider and commissioner organisations) would create the programme team and ensure the formation of the detailed programme plan within 2 months of the conclusion of the public consultation. The programme team would make sure that all statutory responsibilities regarding the programme of both provider and commissioner organisations will be met.
The Programme would be led by a dedicated Programme Manager, with the team made up of dedicated operational representatives from each provider and commissioner organisation. Additionally the programme will require dedicated finance, HR and estates expertise.

What it would take to implement the proposed changes...

<table>
<thead>
<tr>
<th>Programme Management</th>
<th>Information Systems</th>
<th>Public engagement / comms</th>
<th>Workforce planning and development</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team / workforce:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Team formation drawn from providers &amp; commissioners</td>
<td>• Dedicated PR support embedded within the programme team</td>
<td>• Ongoing programme of public engagement following consultation – tailored to each community situation and needs</td>
<td>• Dedicated Estates Lead (not full time)</td>
<td></td>
</tr>
<tr>
<td>• Linked to Clinical &amp; Professional Reference Group</td>
<td>• Use existing Information Governance workstream group and Derbyshire Informatics Delivery Board (DIDB)</td>
<td>• Workforce engagement too</td>
<td>• Link to each organisation estate function</td>
<td></td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
<td>• Ongoing programme of public engagement following consultation</td>
<td><strong>Processes:</strong></td>
<td><strong>Processes:</strong></td>
<td></td>
</tr>
<tr>
<td>• Programme Office functions developed &amp; implemented</td>
<td>– tailored to each community situation and needs</td>
<td>• Processes:</td>
<td>• Understand community facilities (in addition to community hospitals)</td>
<td></td>
</tr>
<tr>
<td>• Implementation planning &amp; co-ordination</td>
<td></td>
<td>• Ongoing programme of public engagement following consultation – tailored to each community situation and needs</td>
<td>• Plan options for community hub / network development (health, social, other LA, voluntary, ...)</td>
<td></td>
</tr>
<tr>
<td>Performance metrics defined and used to adapt and refine the changes</td>
<td></td>
<td>• Ongoing programme of public engagement following consultation – tailored to each community situation and needs</td>
<td>• Establish formal partnership (union) links</td>
<td></td>
</tr>
<tr>
<td>• Statutory body assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Financial management / control</strong></td>
<td><strong>Information Systems</strong></td>
<td><strong>Public engagement / comms</strong></td>
<td><strong>Workforce planning and development</strong></td>
<td><strong>Estates</strong></td>
</tr>
<tr>
<td>• Budget established for Programme Office</td>
<td>• Dedicated PR support embedded within the programme team</td>
<td>• Ongoing programme of public engagement following consultation – tailored to each community situation and needs</td>
<td>• Dedicated Estates Lead (not full time)</td>
<td><strong>Team / workforce:</strong></td>
</tr>
<tr>
<td>• Governance established for Programme Team (Delegated Authority)</td>
<td>• Use existing Information Governance workstream group and Derbyshire Informatics Delivery Board (DIDB)</td>
<td>• Workforce engagement too</td>
<td>• Link to each organisation estate function</td>
<td>• Dedicated Estates Lead (not full time)</td>
</tr>
<tr>
<td>• Co location of team essential (site to be identified)</td>
<td>• Ongoing programme of public engagement following consultation – tailored to each community situation and needs</td>
<td>• Establish formal partnership (union) links</td>
<td></td>
<td>• Dedicate Estates Lead (not full time)</td>
</tr>
</tbody>
</table>

See Workforce Planning section of this PCBC

North Derbyshire 21C JoinedUpCare - Community Hubs Pre Consultation Business Case – Stage 4 FINAL
Key messages within Consultation Document
Key messages emerging from the messaging session
Next step is to finalise messaging by w/e 26 February

Overarching themes

• Experts say many people are mentally and physically better off at home with the support of community-based services rather than in hospital
• We’ve been listening to North Derbyshire people who tell us they want more services closer to home
• So over the past few years more people have been enabled to get the community-based support they need closer to home to avoid an unnecessary inpatient stay
• Now we know it works it’s the right time for a bigger push to make sure everyone gets the right care in the right place
• People can rely on us to get this right: we’ll do it with you while building on our extensive experience of the positive changes that we’ve already made
• No service will stop until an alternative is in place
• Using our resources better means more money for high quality services not for beds in out-of-date buildings that no longer serve patients best
• Give us your views and help us to shape the proposals

Community rehabilitation beds

• ‘No bed like your own bed’ so let’s keep you at home, if we can, near the ones you love and trust
• These days many hospital-based services can easily be provided to a high quality nearer to people’s homes
• If medically needed then a quick burst of inpatient treatment is best say doctors and nurses
• Experts agree long hospital stays mean older people lose too much strength, independence & confidence
• Everyone who needs hospital treatment will get it

OPMH beds and DRRT

• Everyone with dementia who needs intensive psychiatric inpatient treatment will get it
• There’s a time and a place for a hospital stay: experts now agree only the very sickest dementia patients need inpatient treatment
• Better community-based services for all so people with dementia can stay nearer home where experts say they are happiest and do best
• Tell us what the new services should look like

Dementia Day Care Unit

• North Derbyshire people want more services closer to home & that’s what we’re proposing
• People with dementia are happiest at home so services should be provided nearer to them
• Old to new model: we will strengthen the quality of community services

Learning Disabilities

• Our plan is in line with the new national plan
• Enable remaining small groups living in NHS hospitals to finally have a home of their own with the support they need
• Person-centred care where people and carers control their own budgets so they can choose right services for them
• Won’t change overnight and we will make sure new services are in place before current services stop
• Guarantee replace existing respite care with the same amount of choice of quality services
• No more disjointed services as the local authority and the NHS are pooling their budgets for the first time to make sure people seamlessly get services in the way they need
Key messages within Consultation Document
Site implications and urgent care are under development...

Site implications
- North Derbyshire people tell us they want services nearer to home
- Doctors, nurses and therapists say most people do better out of hospital and in the community
- These days many hospital-based services can be provided to a high quality nearer to people’s homes if we make the right investments in the community
- We’re already making it possible for people to avoid unnecessary admissions
- With new services in place we can look after people better at home, so fewer people will need to go to hospital as only the sickest will still need inpatient treatment. This means that less beds are necessary
- No service will stop and no beds will be removed until an alternative is in place
- We’ve a duty to make best use of all resources - this means in time redirecting funds from unoccupied beds and under-occupied buildings and investing in quality services
- There are two community hospitals in Bolsover and Newholme which won’t be needed for inpatient beds when the new way of caring for people nearer home is established
- Other hospitals are not being considered at this time because they house in patient services or other activity that can’t be easily relocated such x-ray and urgent care facilities
- [Patient stories will enable moving the view from loss of facility to improving patient experience – what kind of services will be provided out of hospital? ]
- Give us your views and help us to shape the proposals to deliver the best possible care to people

Urgent Care
Key emerging issues:
- Lack of sustainability of existing model
- Innovative alternatives to traditional model, i.e. mobile service delivery & 111
- Track record of innovation improving quality, e.g. falls vehicle and acute visits
- Need for conversation with public and stakeholders about need for change and the range of alternatives within constraints

Next Steps:
- Share site implications with other subject matter experts and develop to sign-off
- Draft and share urgent care messages with other subject matter experts and develop to sign-off
Consultation approach and plan
The work is in early stages and requires intensive work to ensure that activities are completed within timeframe

Consultation plan overview:
• Formal plan required by NHSE as part of assurance documentation
• Formal plan further developed by communications and engagement working group into a tactical plan for internal use to deliver consultation activities in line with CCGs’ business objectives
• Messaging underpins both plans

Formal plan key components:
• State CCGs’ understanding of their duties and setting out the consultation principles
• Why the CCGs are consulting
• Who the CCGs intend to consult with (list of stakeholder groups and localities)
• How, when & where the CCGs intend to consult with those groups (channels to be used)
• How people can respond to the consultation and how the CCGs will consider their responses and determine the impact on the final decisions (metrics and impact)
• Implementation plan covering:
  • Pre-consultation phase counting down from six weeks to consultation launch
  • Consultation phase activity planned from week 0 to week 12

Tactical plan approach:
To articulate a compelling narrative backed with key evidence in a confident and proactive manner to engage stakeholders in a meaningful consultation process. Activity will be phased to align with the consultation process: preparation, pre-consultation, consultation, post-consultation.

There are two approaches to communications and engagement:
• **Minimal**: Typically characterised by low-key and relatively low activity which meets the basic requirements of the consultation process
• **Extensive**: Typically characterised by high-profile and relatively high levels of activity driven by a desire to engage fully with stakeholders

And, what happens in practice is there is a continuum between the two.
Tactical Planning: overview of timeline and phased activity

The suggested activities listed are not exhaustive and are being developed at present into an implementation plan

1) Preparation phase: February to week -6
   • Pre-consultation meetings/briefings with key influencers and key stakeholders most affected by the proposals
   • Drafting and developing consultation document with stakeholder/expert input
   • Drafting and development of consultation questions and process with input of independent consultation expert
   • Complete signed-off messaging; produce collateral; develop response mechanism, collation and analysis of consultation responses
   • Identify and develop consultation ambassador pool: clinicians, AHPs, nurses, social care, CCG exec and GB, voluntary sector, patients, public
   • Planning communications and engagement activities for phases 2 & 3

2) Pre-consultation phase: Week -6 to week 0
   • Final preparations for consultation materials hosting/distribution
   • Warm-up to consultation launch with content:
     • Reminder of drivers for change
     • Overview of work to date
     • Patient & staff stories about existing community-based services
     • Promote consultation principles/integrity of process
     • Flag countdown to start of consultation and overview of activities
   • 21C newsletter, CCG and partner corporate channels, third-party channels, media push early March
   • Agenda item updates via stakeholder routine meetings delivered by appropriate CCG staff
     • Prioritise face-to-face engagement of key influencers and stakeholders in priority localities
     • Considerations: extent of pre-briefing/likely outcome

3) Consultation Phase: Week 0 to week 12
   • Staff briefings day before launch by CCGs
   • Day of consultation launch
     • Media, staff and priority stakeholder launch/meetings
     • Documents publicly available
   • Regular responsive review of activities throughout consultation
   • Programme of stakeholder meetings in routine and additional proactive pre-booked and request slots
   • Programme of independently chaired public meetings with consultation ambassadors
   • Programme of regular media activity, updates through corporate and third-party channels
   • Mid-point assessment of emerging themes – media push
   • Stakeholder events/ small-scale ‘workshop’ public events plus focus groups with ‘hard-to-reach’ groups/protected characteristics
   • Countdown to consultation close and ‘Have your say’ media push

4) Post-consultation Phase: Week 12 to final decision
   • Collate, weight and analyse consultation responses and agree any changes to the proposals following consultation
   • Governing Bodies and Boards separately consider a summary of the consultation responses, together with the amended business case for approval
   • In the case of the two CCG Governing Bodies reaching different decisions representatives from each of the CCG Governing Bodies will hold a joint committee to reach a single joint decision by which both CCGs will abide

5) Implementation Phase: Final decision to roll-out of service change
Conclusions
Conclusions and next steps
Commissioners believe the cases proposed are compelling from quality of care, access and financial perspectives.

Conclusions from PCBC Stage 1
The proposals for OPMH and community bedded care are both consistent with the overall intention to provide more effective joined up care which is delivered wherever possible within communities.

In both cases, the proposal is to deliver c.50% of the care currently delivered through inpatient hospital care instead through multidisciplinary teams operating within communities.

Where specialist bedded care is still necessary, there are 2 slightly differing approaches to where the services should be located:

- For Specialist OPMH, a single centre of excellence providing ‘step up’ care as need becomes more ‘acute’. Here, centralising the specialist capabilities makes sense for the c.150 patients per annum who will need such care.
- For specialist rehab care, 2 units (one in Chesterfield and one in Buxton) offer the best balance between the need for specialist capability and enabling the ‘step down’ pathway back to the person’s own community for c.500 patients per annum.

Overall, the combination of the 2 proposals would offer a cost avoidance of c.£6m with the potential to save an additional up to £2.7m if stranded costs can be rationalised.

In both cases, there would be a small reduction in the overall number of health staff (WTEs), but there would be a significant change in the skill mix required (fewer nurses but more specialists and therapists). Also, an increase in the numbers of additional social care workers to support people being cared for at home instead of in hospital.

And, moving from ward based care to a community based care presents significant workforce development challenges. This will need to be carefully planned and managed.

Commissioners believe the cases proposed to be compelling from quality of care, access and financial perspectives. They are also closely aligned to the national and local strategic direction.

Proposals related to community bedded care and specialist OPMH care were approved / agreed by commissioners and the models of care were supported by providers.

Various points related to how the models would be implemented and funded were raised and are being addressed by this stage 3 PCBC.

Conclusions from PCBC Stage 2
The proposals related to support for people with learning disabilities were agreed and supported by commissioners and providers.

The impact of the proposed changes on the community hospital sites was understood. Boards understood that it had not been possible to develop firm proposals related to Urgent Access to Care. They agreed with the intention to nevertheless include the current status of the work and plans within the public consultation process. And, Boards supported an increased focus on the Urgent Care work, and for the remit and the membership of the workstream group to be broadened to better encompass primary and community care in order that an integrated ‘solution’ could be developed.

Conclusions from PCBC Stage 3
Proposals related to Dementia Day Unit services are compelling from quality of care, access and financial perspectives.

The approach to urgent access to care has been updated to ensure that it is driven by the need to ensure a fully integrated service with primary care at its core and that it is in line with National direction.

The implications of the other proposed changes offers the opportunity to close sites at Bolsover and Newholme whilst committing to continue to deliver services within those communities. This would release c.£0.9m per annum to (net of site re-provision costs) which can be reinvested in care provision i.e. get better value for money.

In addition, in readiness for NHS-E gateway review and public consultation, it describes:

- How we have engaged with stakeholders (including the public)
- The processes used to develop the proposals (incl. option evaluation)
- Commissioning, contracting and financial arrangements
- Potential implementation timeline and considerations
- Workforce planning and development
- Risks and mitigations
- An overview of the consultation messages and consultation plan
Agreement /support to date and next steps

All partner organisations have now agreed the following:

1. Specialist Older Persons Mental Health (OPMH): (subject to consultation) Commissioners approved/ Providers supported the proposed changes to OPMH bedded care
2. Community Bedded Care: (subject to consultation) Commissioners approved/ Providers supported the proposed changes to community bedded care
3. Dementia Day Unit services: (subject to consultation) Commissioners approved / Providers supported the proposed changes to Dementia Day Unit services
4. Urgent access to care:
   i. Agreed the recommendation that CCGs lead further work overseen by the System Resilience Group (SRG) reporting to the C21 programme
   ii. Agreed to exclude urgent care from public consultation, but to develop further plans, and thereafter undertake public consultation
5. Learning Disabilities
   1. Agreed in principle to the proposals
   2. Agreed to exclude Learning Disability from public consultation, but to develop further plans, and thereafter undertake public consultation
6. Other services and site rationalisation implications:
   i. (Subject to consultation) Commissioners supported / DCHS approved closure of hospital sites at Bolsover and Newholme with continued delivery of services locally within each community
   ii. Commissioners agreed the continued review of other sites as other service proposals are developed
7. Workforce planning and development – noted the principles; scale and nature of the workforce changes; explanation of why this is achievable
8. Commissioning, contracting and finance –
   i. Noted the overall combined financial scale of the proposed changes
   ii. Approved the proposed cross system commissioning principles
   iii. Agreed the cross system funding arrangements that would be necessary to implement the proposals
9. Implementation – noted the principles, timeline and ‘what it would take’
10. Consultation document and plans – noted the development of the key messages and the outline consultation plan

Boards are now asked to:

1. Note the amendments to the PCBC (NB: these do not change the actual content but provide points of clarification and incorporate Board feedback received at Stage 3)

1. Commissioners approve and Providers support the associated Consultation Document and Plan

And, what’s next?

March: Development of the consultation document and consultation plans
Update PCBC as may be necessary following Board review
Ongoing pre-consultation engagement
Preparation for the NHS-E Gateway Review

April: NHS-E Gateway Review
Update the PCBC and consultation materials
Boards final review PCBC and consultation materials

May: Public consultation launched – subject to Board and NHS-E approvals

September: Governing Bodies and Boards separately consider a summary of the consultation responses, together with the amended business case for approval.
In the case of the two CCG Governing Bodies reaching different decisions representatives from each of the CCG Governing Bodies will hold a joint committee to reach a single joint decision by which both CCGs will abide.