Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

Hull CCG on the

Integrated Care Centre

Version 1.0
September 2015

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Yorkshire and the Humber Clinical Senate
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Version Control

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Version 0.1	6th June 2015	Draft based on Working Group comments	J Poole
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1. Chair's Foreword

1.1 The Senate welcomes the opportunity to work with Hull Clinical Commissioning Group (CCG) on the development of the Integrated Care Centre. The Senate agrees that this has the potential to be an excellent community facility to improve health outcomes for the city's vulnerable older residents. We hope to continue working with commissioners as the detail develops.

2. Summary Recommendations

2.1 In broad terms, the Senate feels unable to answer the point of whether the clinical evidence base for the model is sound as the detail of the model, including the admission criteria, referral protocols, escalation policies and the general pathways of care have not been provided. The Senate agrees that the evidence supplied seems largely sound but is unsure whether the centre will fully address commissioner aims. We recommend that further work is needed to be certain that there is a match between the patient population described in the literature and those patients who will use the facility.

2.2 The Senate recommends that the CCG maximises every opportunity to care for patients in their own homes by using outreach teams based within the integrated care centre (ICC). This intention could be made clearer in the documentation.

2.3 The report contains details of specific areas which commissioners are advised to consider further within their developing model and these include the staffing, opening hours, building design and IT infrastructure.

3. Background

Clinical Area

3.1 NHS Hull CCG are developing an Integrated Care Centre in Hull. The centre is designed to enable rapid assessment and improved management of long term conditions in a community setting. In addition, the centre will provide Hull's only purpose built rehabilitation/re-ablement facility. This is a new service designed to provide alternative pathways for principally elderly patients presenting at the acute trust, turning urgent attendances into planned attendances.

3.2 The clinical principles for the development stemmed from three sources:

i. Local GP's indicating they could care for people in the community and keep them in their own homes longer if they had access to a rapid assessment and diagnostic facility

ii. Local hospital clinicians advising the CCG that they had far too many people being admitted to hospital beds who did not need to be there if community support could be improved

iii. Local people indicating that they would prefer to remain at home in the event they need support for as long as possible

Role of the Senate

3.3 The CCG wishes to ensure that they have sought independent clinical advice on the clinical evidence base for the model and have had opportunity for independent review of the proposed clinical models and pathways.

3.4 The Senate has been asked to "provide assurance that the clinical evidence base for this model is sound and that the clinical strategy for service development alongside the physical facility is robust."

3.5 Advice from the Senate fits into the process in terms of providing overall assurance around the clinical efficacy of the proposed service change that this development will help to facilitate. Questions and comments from the Senate will assist NHS Hull CCG in ensuring it has fully considered the clinical risks in so far as could be expected at this stage of the development.

3.6 The draft Outline Business Case (OBC) will be considered by NHS Hull CCG Board on 17th June 2015. The Senate advice will be used to inform the discussion and to assist the CCG in assessing the OBC and its suitability for progression to the next stage which will be to seek final sign off by relevant providers and approval authorities for progression to Full Business Case.

Process of Review

3.7 The Senate received the supporting background information for this review in early April 2015 and agreed the Terms of Reference for the review on the 5th May 2015. The Senate Working Group was fully appointed by the end of April 2015. The Senate received the clinical models containing the detail of the proposal on the 11th May 2015.

3.8 The Senate Working Group held a teleconference to aid their discussions prior to the May Senate Council meeting. At the May meeting, the Council was informed of the Working Group discussions and also had opportunity to comment on the model. The Working Group held a teleconference with commissioners and clinical representatives on 26th May 2015 to clarify outstanding questions formed from those discussions. The Working Group agreed its draft report and submitted this to the CCG on the 15th June 2015. The CCG have opportunity to comment on the report prior to its final ratification by the Council.

Evidence Base

3.9 The underlying evidence base regarding the effectiveness of primary, community and intermediate care is mixed. Where these types of intervention do have some impact, this is limited to a specific disease area or client group.

3.10 Due to the lack of specific guidance, the clinicians involved in this review worked to achieve a consensus based on experience and judgement.

3.11 The Senate has referred to the National Institute for Health Research report[1] to identify the evidence base. The following information is extracted from that report. There is mixed evidence about the impact of community-based initiatives on rates of hospital admission. As the table below demonstrates, the efficacy of many initiatives is disease specific, thus limiting their overall impact.

TABLE 1 - Summary of evidence on community-based initiatives

Intervention	Impact on unplanned admissions	Disease area/client group	Evidence source
Case management	Reduces	Heart failure and some older frail	Purdy *et al.*[2] Purdy[3]
Care co-ordination as part of integrated health and social care teams	Reduces	Older frail	Philp *et al.*[4]
Specialist clinics	Reduces	Heart failure	Purdy *et al.*[2]
Education and self-management	Reduces	Adults with asthma and COPD	Purdy *et al* [2] Purdy[3]
Exercise and rehabilitation	Reduces	COPD and cardiac	Purdy *et al.*[2] Philp *et al.*[4]
Telemedicine	Reduces	Heart disease, diabetes, hypertension and older people	Purdy *et al.*[2]
Telecare	No impact	COPD, diabetes, heart failure	Philp *et al.*,[4] Bardsley *et al*[5]
Virtual wards	No impact	High risk	Bardsley *et al*[5]
Vaccine programmes	No impact	Asthma, COPD, older people	Purdy *et al.*[2]
Medication reviews	No impact	Older people, people with heart failure or asthma	Purdy *et al.*,[2] Philp *et al.*[4]
Falls prevention	No impact	Older frail	Philp *et al.*[4]
Hospital at home	Increases	Elderly patients with a mixture of conditions	Purdy *et al.*[2]

[1] Insights from the Clinical Assurance of Service Reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed method study. National Institute for Health Research.
[2] Purdy S, Paranjothy S, Huntley AL, Thomas R, Mann M, Huws D, et al. *Interventions to Reduce Unplanned Hospital Admissions: A Series of Systematic Reviews*. Bristol: University of Bristol; 2012. URL: www.bristol.ac.uk/primaryhealthcare/docs/projects/unplannedadmissions.pdf
[3] Purdy S. *Avoiding Hospital Admissions: What Does the Research Evidence Say?* London: The King's Fund; 2010.
[4] Philp I, Mills KA, Thanvi B, Ghosh K, Long JF. Reducing hospital bed use by frail older people: results from a systematic review of the literature. *Int J Integr Care* 2013;13:e048.
[5] Bardsley M, Smith J, Steventon A. *Evaluating Integrated and Community-Based Care: How Do We Know What Works?* London: Nuffield Trust; 2013. URL: www.nuffieldtrust.org.uk/publications/evaluating-integrated-and-community-based-care-how-do-we-know-what-works (accessed 1 October 2013).

3.12 There are a wide range of reasons why interventions may not be effective. Bardsley *et al.*[5] suggest that poor implementation is a key obstacle to community-based initiatives achieving significant impact on rates of admission, while Roland and Abel[6] point to risks of supply-induced demand and to community-based alternatives sometimes having poorer outcomes than hospital-based care. Philp *et al.*[4] hypothesised that with further development, some of these interventions may prove effective, given that falls, polypharmacy, poor nutrition and lack of exercise are all associated with increased hospital bed use in older people. Edwards[7] and Simmonds *et al.*[8] highlight the current complexity and lack of coherence across and within services, all of which promote unplanned admissions.

3.13 It is also important to reflect that other outcome measures for community-based initiatives indicate more positive results for patients/service users. For example, evidence shows that there is high patient satisfaction associated with virtual ward[9] and case management programmes.[10]

3.14 Intermediate care beds have the potential to reduce length of stay by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up). It is estimated that England has only half of the intermediate care capacity needed.[11] Although there is no clear correlation between the number of intermediate care beds and the use of hospital beds by older people, the areas with the highest bed use have been found to have excessive lengths of stay for patients for whom hospital was the transition between home and supported living.[12]

4. Recommendations

4.1 The Senate notes how early commissioners are in the process of developing this model of service with the aim to:

- reduce re-admission rates for people over 65
- reduce excess bed days for people over 65
- reduce the number of spells required for people over 65

4.2 The Senate has been asked to focus on whether the clinical evidence base for this model is sound and that the clinical strategy for service development alongside the physical facility is robust. In broad terms, the Senate feels unable to answer the

[6] Roland M, Abel G. Reducing emergency admissions: are we on the right track? *BMJ* 2012;345:e6017. http://dx.doi.org/10.1136/bmj.e6017

[7] Edwards N. *Community Services: How They Can Transform Care*. London: The King's Fund; 2014.
[8] Simmonds RL, Shaw A, Purdy S. Factors influencing professional decision making on unplanned hospital admission: a qualitative study. *Br J Gen Pract* 2012;62:e750–6. http://dx.doi.org/10.3399/bjgp12X658278
[9] Oliver D, Foot C, Humphries R. *Making Our Health and Care Services Fit for an Ageing Population*. London: The King's Fund; 2014.
[10] Ross S, Curry N, Goodwin N. *Case Management: What Is It and How Can It Be Best Implemented*. London: The King's Fund; 2011.
[11] NHS Benchmarking Network. *National Audit of Intermediate Care Report 2013*. London: NHS Benchmarking Network; 2013.
[12] Imison C, Poteliakhoff E, Thompson J. *Older People and Emergency Bed Use: Exploring Variation*. London: The King's Fund; 2012.

point of whether the clinical evidence base for the model is sound as the detail of the model, including the admission criteria, referral protocols, escalation policies and the general pathways of care have not been provided. Commissioners may want to consider widening access to a lower age range of patients once their pathways are more developed. The Senate would be very happy to assist commissioners in reviewing the model as this further develops.

4.3 The clinical model sets out assumptions on the population who will use this centre.

- 25-30% of patients who currently attend A&E and ambulatory care and do not need a bed
- GP referrals for patients who need to see a consultant and for those who have the potential of becoming acutely ill and who need diagnostics – these will be via scheduled appointments

4.4 The Senate agrees that the evidence supplied seems largely sound but is unsure whether the centre will fully address commissioner aims. Commissioners are seeking improved co-ordination between GP and community services to maintain people in their own home and for this centre to provide alternatives for some GP admissions to hospital. We have greater confidence in the Long Term Conditions part of the assumptions but less so on the impact this centre will have on reducing admissions to the Emergency Department. We recommend that further work is needed to be certain that there is a match between the patient population described in the literature and those patients who will use the facility. It will be difficult to identify that 25% cohort who attend A&E and do not require a bed and ensure their care is delivered through the Integrated Care Centre (ICC). Page 14 figure 3.4 of the clinical model, estimates that 2223 cases per annum could transfer to the ICC which is 6 cases per day but page 16 estimates that 30 – 50 per day will present for assessment. The Senate is unsure of the assumptions behind this figure and recommends that there is more transparency on this. It is noted that Commissioners have been working with providers to develop other models of care that can be based within the Integrated Care Centre such as the frailty project.

4.5 The Senate recommends that the CCG maximises every opportunity to care for patients in their own homes by using outreach teams based within the ICC. We recommend that commissioners explore how the model can ensure a community based outreach model which supports patients in their own home. The Senate felt that the information currently supplied presents quite a medically focused model of care. Commissioners are advised to explore further the interconnections between this centre and the community to strengthen the model and ensure that they maximise the opportunities for assessing patients within their own home. The model would benefit from the inclusion of integrated discharge teams and admission teams with more joint working with housing and social care to focus on rehabilitation and re-ablement. There are also potential models where the Community Geriatrician is used innovatively, (hot desk advice, fast track clinics or assessing elderly patients in their care home). The 5 Year Forward View promotes the multi-disciplinary community model and the Senate advises that currently the proposals do not

adequately address those opportunities and community based solutions will need to be a fundamental part of commissioners longer term strategies.

4.6 The Senate recommends commissioners consider the following specific areas as they develop the proposals for the centre:

i. Elderly patients with co-morbidity and long term conditions are complex and therefore there is work to be done to identify the right patients for this centre before they arrive. The Senate understands that referrals into the centre will be taken from GPs, Long Term Condition practitioners, nurses, A&E and that paramedics will not be referring patients to the centre. Thought needs to be given to this process of identifying the right patients for this centre, supported by clear protocols and criteria. Clearly understood escalation policies are needed for those patients admitted to the wrong place.

ii. There is currently no detail on the staffing model. The Senate understands that a number of community services and their staff will transfer into this centre. The Senate is unsure whether it is intended that there will be a senior physician on site over 7 days and commissioners need to be certain that they can recruit to those positions. Commissioners will wish to consider the use of Community Geriatricians to support the model.

iii. The Senate also questioned how commissioners can ensure that the diagnostic facilities are maintained throughout the opening hours given the relatively small numbers of patients accessing this service. Commissioners need to ensure that the staffing cover is robust enough to maintain this service. The financial viability of this model is outside of the remit of the Senate.

iv. The hours of opening for the Centre are 9am to 10pm 7 days a week. The Senate understands the rationale for these opening hours from the data presented. In discussion with commissioners, we understand that for patients who do present at a late hour, the care pathway will include local community procurement which will enable intermediate care services to be utilised. The patient will be placed in a community bed or transferred back to their home and a follow-up visit can be arranged for the next day. The services which the Local Authority can provide will also be linked into this pathway. The Senate recommends that further thought is given to how these patients will be discharged as it is unlikely that there will be enough ambulances available between 9 and 10pm to transport them. Commissioners may also want to consider that some re-ablement requires 24 hour care and this facility will not be able to accommodate this patient group.

v. The Senate has some concerns with the design of the building and further detail on this can be provided to commissioners if they would find this helpful. Our concerns are particularly with regard to accessibility for patients (travel times/ public transport/parking, accessible toilets, storage for wheelchairs, the size of some of the rooms and therefore potential difficulties with wheelchair access and ability to manoeuvre trollies). The Senate understands that the design is in the

early stages and will remain flexible in order to support several different models of care. It is also noted that a Public Engagement Group was formed by the CCG and they held extensive talks around the best location for the centre, egress and access, supported by a detailed transport report. Commissioners have informed the Senate that they will engage patients in the design of the building once the model is more fully worked up and the Senate endorses the need to discuss the proposals in more detail with patients.

vi. The information received by the Senate did not contain reference to the IT function which will be key to this model of care working effectively. From discussion with commissioners, the Senate understands that this centre will provide an opportunity to explore the use of an integrated IT system which will facilitate information sharing between the Trust, Local Authority and community teams. Work is currently being carried out on a secondary computerised care system which includes Picture Archiving and Communication System (PACS) and allows access to haematology data. This work is known as the Lorenzo Project and is expected to be rolled out across the city in October 2015. It is expected that the Integrated Care Centre will be linked into this system. Commissioners may want to consider alternative IT strategies as contingency if the planned IT infrastructure is not completed to timescale.

5. Summary and Conclusions

5.1 The Senate thanks Hull CCG for the opportunity to work with them on this development which has the potential to provide an excellent alternative to traditional models of care.

5.2 The Senate recommends that the CCG maximises every opportunity to care for patients in their own homes by using outreach teams based within the ICC.

5.3 The proposals are in the early stage of development and further detail is required on the detail of the model before the Senate can agree that the clinical evidence base for the model is sound. The Senate agrees that the evidence supplied seems largely sound but would question whether the centre will fully address commissioner aims and further work is needed to be certain that there is a match between the patient population described in the literature and those patients who will use the facility.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Senate Council Members

Jeff Perring
Paediatric Intensive Care Consultant, Sheffield Children's Hospital NHS Foundation Trust

Steve Ollerton
Clinical Leader, Greater Huddersfield Clinical Commissioning Group

Mark Millins
Lead Paramedic, Yorkshire Ambulance Service

Senate Assembly Members

Peter Allen
Citizen Member

Philip McAndrew
Consultant Radiologist, Barnsley NHS Foundation Trust

Ali Asem
Consultant Geriatric Physician, Northern Lincolnshire and Goole NHS Foundation Trust

Ellie Monkhouse
Director of Nursing, NHS Leeds North Clinical Commissioning Group

David Smith
Deputy Divisional Clinical Director, Diagnostics and Therapeutics, Bradford Teaching Hospitals NHS Foundation Trust

Beverley Snaith
Lead Consultant Radiographer, Mid Yorkshire NHS Trust

Richard Gurney
Clinical Lead – Occupational Therapy, Leeds & York Partnership NHS Foundation Trust

Rebecca Bentley
Senior Nurse in Primary & Secondary Care, Bradford District Care NHS Foundation Trust

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Senate Council Members and Working Group members were asked to declare any possible conflicts of interest that could interfere with their participation in this review. No Conflicts of Interest were declared

Appendix 3

TERMS OF REFERENCE

Template to request advice from the Yorkshire and the Humber Clinical Senate

Name of the lead (sponsoring) body requesting advice: NHS Hull CCG

Type of organisation: Commissioning body

Name of main contact: Jackie Hadwen

Designation: Project Manager, Hull Integrated Care Centre

Email: jackie.hadwen1@nhs.net **Tel:** 07787 740813 **Date of request:** 24th March 2015

Please note other organisations requesting this advice (if more than the lead body noted above):

NHS Hull CCG

Is the Senate being consulted for advice or as part of the formal assurance process?

Advisory role. Not formal assurance

Please state as clearly as possible what advice you are requesting from the Clinical Senate and what documentation you propose sharing with the Senate.

NHS Hull CCG are developing an integrated care centre in Hull. The centre is designed to enable rapid assessment and improved management long term conditions centre in a community setting. In addition the centre will provide Hulls only purpose built rehabilitation/ reablement facility. This is a new service designed to provide alternative pathways for principally elderly patients presenting at the acute Trust, turning urgent attendances into planned attendances.

The CCG would like the Senate to provide assurance that the clinical evidence base for this model is sound and that the clinical strategy for service development alongside the physical facility is robust. The Senate will be provided with:

- The early stage plan
- Public consultation document
- Kings fund video
- Background information on Hull 2020
- Draft site map
- The draft outline business case section which will contain the clinical evidence base, the proposed clinical models, the modelling of patients and potential impact on activity currently undertaken in other locations.

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

The CCG wishes to ensure that they have sought independent clinical advice on the clinical evidence base for the model and have had opportunity for independent review of the proposed clinical models and pathways.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

The draft outline business case will be considered by NHS Hull CCG Board on 17th June. The Senate advice will be used to inform the discussion and to assist the CCG in assessing the OBC and its suitability for progression to the next stage which will be to seek final sign off by relevant providers and approval authorities for progression to FBC.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved).

The clinical principles for the development stemmed from three sources:

1) Local GP's indicating they could care for people in the community and keep them in their own homes longer if they had access to a rapid assessment and diagnostic facility.

2) Local hospital clinicians advising the CCG that they had far too many people being admitted to hospital beds who did not need to be there if community support could be improved.

3) Local people indicating that they would prefer to remain at home in the event they need support for as long as possible.

A series of workshops and discussions were held involving local clinicians and GP's. From this broad agreement was reached that:

- Alternatives are needed for some GP admissions to hospital and in particular there was a strong clinical view that the treatment of people with long term conditions needed to improve.
- Improved co-ordination between GP and community services is needed to maintain people in their own home.
- Primary care direct access to diagnostics and senior clinical review is needed on an urgent but planned basis.
- Integrated pathways with wider community partners are needed (e.g.: Social Services, Fire Service, and Voluntary Services).
- The ability to do this within a community setting rather than busy acute hospital setting was deemed important in terms of changing patient culture, expectation and reducing anxiety. Keeping patients clothed and mobile as much as possible and encouraging and supporting independence and self-care.
- A purpose built rehabilitation/reablement facility was needed in the City and would support/ promote living independently for longer and increase capacity in line with expected increases in demand.
- Rapid Assessment should not be a 'walk in' service but clinician to clinician to referral.
- The opportunity to have community based clinics and services supporting long term conditions management as part of an integrated provision should be taken.

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

No external clinical advice outside the immediate health economy has been sought.

When is the advice required by? Please note any critical dates.

The draft OBC will subject to affordability reviews currently taking place be submitted to NHS Hull CCG Board on 17th June 2015. The commissioners would like the Senate advice to be provided at the beginning of June 2015 and will make the relevant draft section of the OBC available.

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

The draft Outline Business Case will be subject to scrutiny and comment from:

- Providers
- NHS England Project Appraisal Unit
- NHS Property Services
- Community Health Partnerships
- NHS Hull CCG Board
- Hull Health and Wellbeing Board

Advice from the Senate fits into the process in terms of providing overall assurance around the clinical efficacy of the proposed service change that this development will help to facilitate. Questions and comments from the Senate will assist NHS Hull CCG in ensuring it has fully considered the clinical risks in so far as could be expected at this stage of the development.

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

The initial design of the facility maximises flexibility to ensure that different service models can be commissioned and function from the accommodation over time. In the NHS we know that service change and improvement is a constant and in order to achieve new models of care in line with the Five Year Forward View flexibility of accommodation will be key. Two principal streams of service development work associated with the project are taking place:

1) NHS Hull CCG Community Services Procurement – this procurement which is currently in progress contains specifications indicating the requirement for radically different service models to be provided. Of particular relevance to the Integrated Care Centre are the Care Group 3 specifications. The Clinical Senate has already reviewed the specifications and provided advice which has been incorporated.

2) Work with NHS Hull CCG's main acute provider, Hull and East Yorkshire Hospitals NHS Trust looking at identifying the potential numbers of patients suitable for assessment in a community based assessment facility and how to transition from current provision especially in regard to long term conditions and frail elderly.

Please send the completed template to: joanne.poole1@nhs.net. For enquiries contact Joanne Poole, Yorkshire and the Humber Clinical Senate Manager at the above email or 01138253397 or 07900715369

Appendix 4

BACKGROUND INFORMATION

The following evidence was supplied to the Senate:

- Floor Plan A_MA_715_SK_00_010_PO5
- Hull Integrated Care Centre Consultation Document
- Hull 2020 Making a Better Future Together Partnership Strategy Document
- Hull Integrated Care Centre The Clinical Model for Outline Business Case Stage