North Derbyshire JoinedUpCare

Community Hubs
Strategic Outline Case

Version: Final
Date: 13th November 2014

Executive Summary

This Strategic Outline Case sets out the context, case for change and planned approach to the development of the **'Community Hubs' - places from which joined up out of hospital care will be delivered across North Derbyshire.**

Context:

Community hubs are a critical element of the whole 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 JoinedUpCare services including improving access to urgent and planned 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'.

Case for Change:

Community hubs will:

(i) Improve the quality of care – supporting independence at home wherever possible. Currently, too often:
- Poor coordination of care leads to crisis response and increased bedded care
- Bedded care (particularly for frail elderly people) leads to greater dependency and rapid deterioration

(ii) Improve access to care – to respond to the changing needs
- Increasing numbers of older people with complex, ongoing care needs (mental, physical and social)
- People cannot always access urgent care 7 days a week

(iii) Improve service effectiveness
- Care services are currently too often fragmented and uncoordinated resulting in a lack of continuity and duplication

Financially, the North Derbyshire 5 Year Plan describes an aiming point for how the system plans to use its resources in 2018/19, including the major changes that will be required to address the underlying £150m financial challenge. A critical element of this relates to the funding of community based services.

The 5 Year Plan anticipates increasing funding in community based services but also significantly changing how this is used (less bedded care and more joined up services).

Planned Approach:

The intention is to develop our Community Hubs with our stakeholders and the public through wide scale engagement and involvement. The needs of people varies across North Derbyshire so 'not one size will fit all' and we will work with 8 local communities to consider options which meet their specific needs.

Although this document outlines some of the ways in which changes can be made; these will be subject to further discussion and development throughout the pre-consultation engagement period.

This approach to designing our community hubs will ensure that services are discussed with people; giving them the opportunity to influence the development. By providing people in local communities with an understanding of the system pressures and benefits that the wider changes will also bring, we will be 'telling the whole story' to help them make more informed choices.

We will ensure models designed demonstrate affordability, greater efficiencies , longer term viability and sustainability of services; whilst improving access, responsiveness, quality and support JoinedUpCare.

A timeline sets out the high level milestones and activities required to deliver the intentions set out in this Strategic Outline Case.

Purpose, structure and contents of the document

Purpose

This Strategic Outline Case sets out the context, case for change and planned approach to the development of the **'Community hubs'.**

It clarifies the scope and rationale for how community hubs fits within the 5 Year Plan.

The SOC will be reviewed (for approval) by the 21C Plan Delivery Group and subsequently reviewed by stakeholder Boards to confirm their ongoing commitment to the programme.

Approach

This Strategic Outline Case has been developed through:

- The Community Hub work stream; which consists of Commissioners (Health & Social Care) and Providers
- Constant ongoing dialogue with leaders (clinical, professional, managerial) within and across all Commissioning and Provider organisations to ensure ownership and consent to move forward on the plan
- Ongoing engagement with service users and the public
- Countywide and National policy and thinking; and is consistent with the NHS Five Year Forward View (October 2014)

Structure of this document

The document provides:

- The strategic context in relation to community hubs and fit with the wider system plan
- A description of the need for change
- Narrative describing the current position and how the future could look
- An overview of the planned approach to developing the community hubs.

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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 joined up community based care services.

The North Derbyshire Five Year System Plan

Health and Care Commissioners and Providers in North Derbyshire have worked together to develop a 5 Year 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.
- Clinicians, professionals, commissioners and providers recognise 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 new system 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 service 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.

A number of positive changes have already been made across North Derbyshire; the aim is to continue learning from these and to increase the scale and pace at which change is delivered to address the changing needs of our population in a sustainable and affordable way.

What do we mean by 'community hubs'?

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).
- Potentially 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 North Derbyshire concept of 'community hubs' is consistent with the *NHS England Five Year Forward View (October 2014)* in particular, (i) the emerging models of care; (ii) the need to design and organise services which are locally appropriate to strengthen 'out of hospital' care.

'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. Crucially, it will link with, and be dependent upon, other work to develop JoinedUpCare services including improving access to urgent and planned care services.

Strategic Context

Community Hubs will be developed to meet the specific needs of local communities; in a way that anticipates on going 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, 8 community areas (covering the whole of North Derbyshire) have been identified.

These are represented on the outline map:

1. Dronfield & North East
2. North Bolsover
3. Chesterfield East
4. Chesterfield Central
5. South Hardwick
6. Dales
7. Buxton
8. High Peak

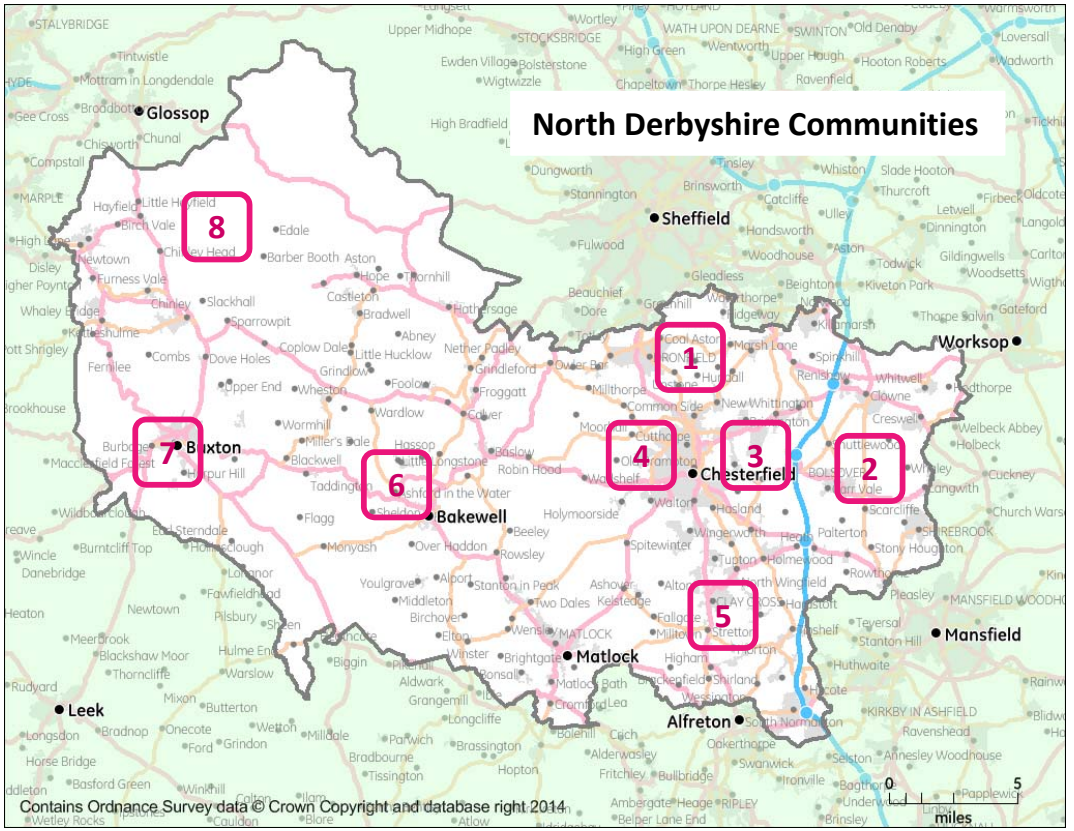
These names may be adapted further to better reflect how these communities are known.

It should be noted that by considering the needs of the 8 local communities, 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. This will be determined through the process by consideration of options for how best to meet the needs.

Progressive Development

As JoinedUpCare becomes successful in helping people to maintain independence, the role of community hubs will necessarily need to develop.

Therefore, 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'.



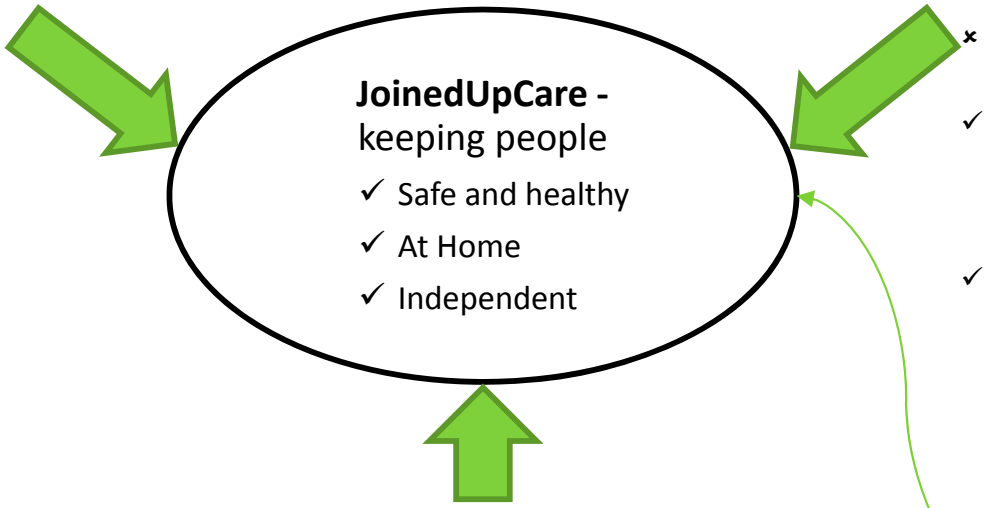
Service Case for Change: Overview

Fundamentally, we need to better meet the changing needs of our population – 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.

This section outlines why our services must change and why organising our community based services differently is a vital part of the changes we need to make.

Improving the quality of care – supporting independence at home wherever possible:

- × Poor coordination of care leads to crisis response and increased bedded care
- × Bedded care can lead to greater dependency and rapid deterioration
- ✓ Locally appropriate set of 'out of hospital' services to improve coordination and support



Improving access to care – meeting changing needs:

- × Changing population with increasing numbers of older people with associated health and social care needs
- × People cannot always access urgent care 7 days a week
- ✓ Increasing service expectations including changing attitudes to take responsibility for self management to maintain independence
- ✓ Services designed so the right care is provided in the right place at the right time

Services which are:

- ✓ *Safe*
- ✓ *Caring*
- ✓ *Responsive*
- ✓ *Effective*
- ✓ *Well led*

Improving service effectiveness :

- × Care is too often fragmented and uncoordinated resulting in a lack of continuity and duplication
- ✓ JoinedUpCare will improve working across organisational boundaries to maximise the use of health and social care resources

Service Case for Change:

Improving the quality of care – supporting independence at home wherever possible

Why do we need to change?	Which can be addressed by…
We know that we can support people with complex care needs to maintain independence for longer if we work with them and their families to plan support needs in advance. In North Derbyshire we do not always do enough to support people with complex care needs. Consequently, there is sometimes a lack of care planning and co-ordination to avoid or rapidly respond in times of crisis. In North Derbyshire, we have already moved a lot of care into the community from hospital services and people tell us that this is a model that they prefer. But, our services are still too focused on people needing to be in a bed in a hospital. We know that the longer people (particularly frail elderly people) spend in any kind of bedded care, the more dependent they become and the quicker their health and well-being deteriorates. References: *'Making our health and care systems fit for an ageing population'*, (The Kings Fund, March 2014); *'System Leadership'* (The Kings Fund, October 2014); *'Specialists in out-of-hospital settings'* (The Kings Fund, October 2014)	Providing a set of local 'out of hospital' services (community hubs) aimed at keeping people at home and independent wherever possible. Hubs will bring together staff providing physical, mental health and social care into one service, often in one place, supported by shared information systems and better technology. Teams focused on proactive care i.e. planning care with individuals and carers to identify and prevent possible problems and keep people safe and healthy. This will include helping people to manage their own conditions where appropriate Those who need it having a named care co-ordinator to co-ordinate their care between professionals, services and organisations making sure they get the right care in the right place at the right time. Care moving away from people being looked after in a bed to them receiving the support they individually need available from communities.

Service Case for Change:

Improving access to care – meeting changing needs

Why do we need to change?	Which can be addressed by…
North Derbyshire's population is growing and changing rapidly. The number of people over 65 set to rise by 12% in 5 years; those over 80 will rise by 16%. The numbers of people with conditions such as heart disease, diabetes and hypertension are also increasing. The current way we deliver services cannot grow to meet these needs (there are insufficient nurses, doctors, facilities, etc..). People cannot always get urgent care 7 days a week, including urgent access to GP services - so often end up inappropriately in acute or nursing home care. Sometimes, people have to travel to hospital for some services such as outpatient clinics or diagnostic services which could be provided closer to their homes. People have increasing expectations of care services. Peoples' attitudes and expectations to take responsibility for their own health and care will continue to evolve.	Organising our health and social care teams differently in community hubs, in a more joined up way around the needs of individuals and communities, so that we provide the right care in the right place at the right time and with the best use of the resources we have. Community hubs ensuring there is a faster and consistent same day, every day access to primary care (and community services) for people with urgent care needs. This is likely to mean general practice, out-of-hours services, community health and social care teams and the NHS 111 service working together, and differently, to ensure that people with urgent care needs can receive prompt advice and care 24 hours a day, seven days a week. Community hubs providing, where appropriate, a base in the community for some specialists to come out from their hospital to either provide care or support community staff to develop a wider range of skills to provide more specialist care in or near people's homes. Through this we ensure specialist interventions augment local provision as a seamless part of care planning and delivery Better use of technology helping service users, their carers and professionals. This will result in sharing of information, technology (tele-health) designed to help people manage their own conditions as well as enable professionals to support and monitor people in their own homes, offer remote consultations to save travelling and better access to advice and provide guidance for care providers.

Service Case for Change:

Improving service effectiveness

Why do we need to change?	Which can be addressed by…
When someone gets to one of our buildings, it is not always the best setting to provide the best care. It is sometimes of poor quality and not in the right place, leading to people not always being cared for in the best setting. Progress in recent years in moving away from bed based care has left some small, isolated wards in community hospitals. This means it is more difficult to maintain high quality and effective care – thus increasing clinical risk. Some service teams are not large enough or are too specialist to offer flexibility to meet changes in demand and needs. Health, social care, voluntary sector and housing organisations are not working together as consistently as we could meaning continuity of care is not always provided. People often have to give the same information many times and they find moving from one service to another difficult. There are lots of handoffs and inadequate sharing of information. Staff experience frustrating duplication of work and cannot provide the compassionate and continuous care they would wish.	Bringing health and social services together meaning the services can be specific to the needs of the local community. They can be provided on a scale which meets the growing needs of communities and be more able to deliver 7 day working and manage the necessary staff recruitment, for example. Working together to use all our buildings and information systems more effectively. Routinely involving voluntary sector and housing teams in our building and service plans Bedded care still being available where more intensive care is needed but with much better community based support and in appropriate settings. This should include those in care homes receiving help as soon as it is needed, for example. Care-co-ordinators and good care planning will lead to much easier access to services, in the right environment with less form filling and reduced repetition of the same information. Staff being enabled to provide continuity of good quality care thus experiencing higher levels of satisfaction and so better able to provide the right care at the right place at the right time. Effective staff support mechanisms such as specialist supervision and integrated governance arrangements.

Financial Case for Change - Overview

The 5 Year Plan describes a financial plan (aiming point) for how the system plans to use its resources in 2018/19, including the major changes that will be required to address the underlying £150m financial challenge.
A critical element of this relates to the funding of community based services.

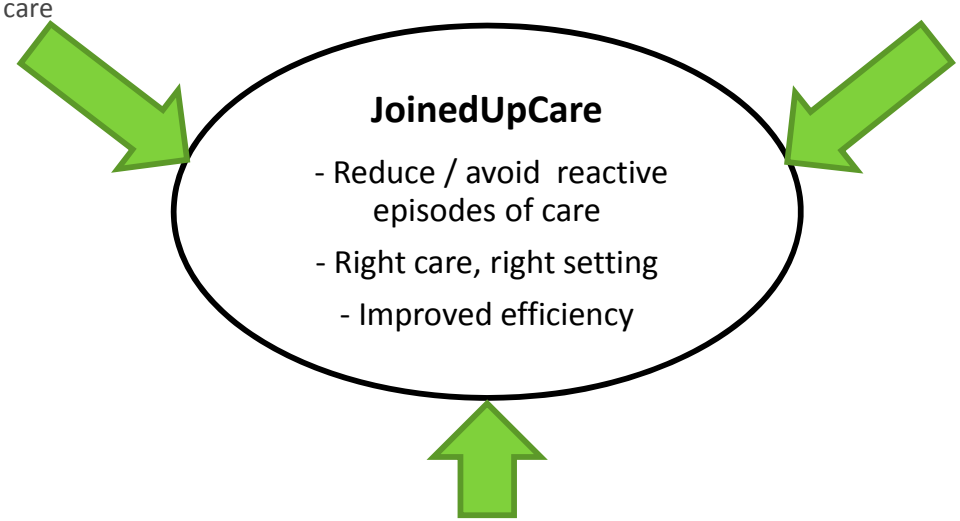
The figure below highlights how the changes outlined in the [Clinical Case] align to the financial case to (i) reduce / avoid reactive episodes of care; (ii) deliver the right care in the right setting; (iii) improve efficiency.

Improving the quality of care – independence at home wherever possible:

- Improved proactive support for people with ongoing care needs to avoid episodes of ill health
- Community based alternatives to bedded care

Improving access to care – meeting changing needs

- Consistent 7 day access to urgent care
- Care closer to home
- Streamlined planned care pathways



Improving service effectiveness :

- Joined up services – reduce duplication & wasted time
- Less fragmented - Improving service resilience
- Right skills – more flexible working
- Improved utilisation of resources (including estates)

Financial Case for Change – Scope and Impact

Existing services currently delivered in community account for an estimated c. £110m (22% of current funding). This is forecast to grow significantly. The 5 Year Plan anticipates increasing funding in community based services but also significantly changing how this is used (less bedded care and more joined up services).

The planning assumptions used in the 5 Year Plan provide a high level view of the scope and scale of change that is planned through changes associated with the community hubs work. Obviously, this work cannot be considered in isolation of the overall system within which it is a critical element.

Community Care Areas:	%	Baseline 13/14:	Forecast 18/19:	Plan 18/19:
Urgent Care	31%	c. £110m	c. £170m	c. £135m
Planned Care	46%			
Bedded Care	23%			

Notes:

1) *These figures only include existing CCG spend on community delivered services (excl. primary care core services).*
2) *In addition, the plan is to significantly reduce/avoid the use of bedded acute care – which will require investment in community alternatives.*

Shows that forecast activity growth and cost inflation would increase the costs by £60m over the planning period.

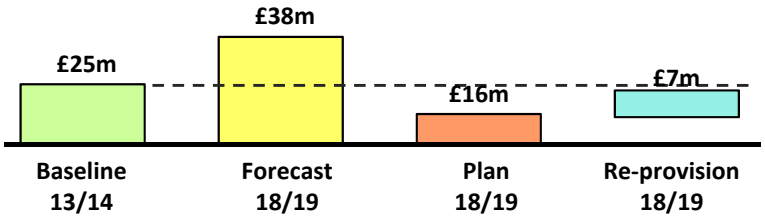
Through changes to (i) reduce / avoid reactive episodes of care; (ii) ensure that the right care is delivered in the right setting (closer to home); (iii) through improved efficiency/effectiveness – the plan is to reduce / avoid the forecast growth by £35m.

Overall, the plan is to increase the investment from £110m to £135m over the period.

The two primary mechanisms by which this will be achieved are:

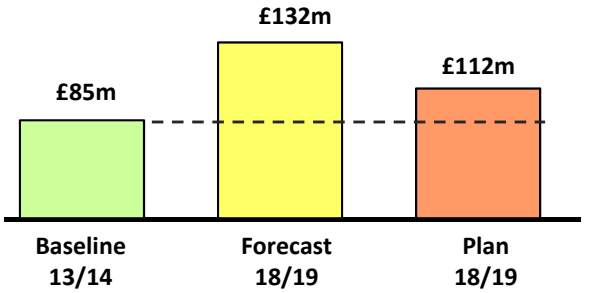
(1) Reduction in <u>bedded community care</u> of c.50%:

- Improved proactive support for people with ongoing care needs to avoid episodes of ill health
- Community based alternatives to bedded care
- Consistent 7 day access to urgent care



(2) Improving the efficiency / effectiveness of <u>planned and urgent care</u> service delivery by c.15%:

- Joined up services – reduce duplication & wasted time
- Less fragmented - Improving service resilience
- Right skills – more flexible working
- Improved utilisation of resources (incl. estates)



Summary of where are we now and what will be different

Services provided from community hubs will be a core part of a health and social care system. Broadly they will provide:
*- **Planned care** services such as outpatient clinics, diagnostic services which people normally make appointments for;*
*- **Urgent care** services such as minor injuries and illness services where people need to be seen more quickly, and:*
*- **Bedded care** services (those locally provided such as respite or rehabilitation) currently provided in community hospitals or nursing homes.*
This section outlines the current position across North Derbyshire and an indication of how services could look in the future.

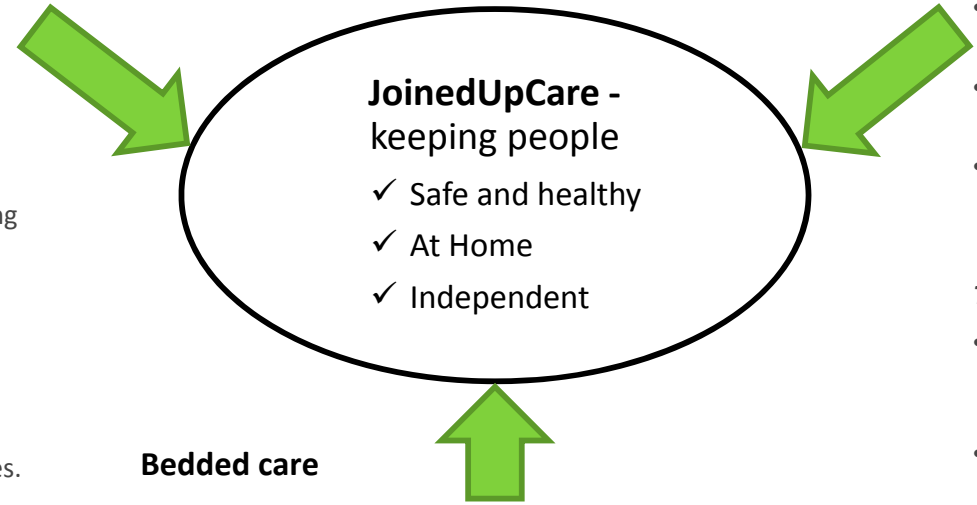
Urgent care

From:

- Different and complex access routes meaning people end up in A&E un-necessarily
- Not always available when its needed.

To:

- People with urgent but non life-threatening needs treated in or near to their homes in the right community setting;
- People with serious or life threatening conditions treated in the right specialist setting;
- Cohesive emergency and urgent network established linked with community services.



Bedded care

From:

- Lack of co-ordinated and proactive care in or near people's homes meaning too many people ending up in bedded care un-necessarily;

To:

- Joined up community services co-ordinating and planning individual's care - preventing needless hospital care;
- Community services available 7 days a week in the right place co-ordinating access to locally provided and specialist provided beds when necessary.

Planned care

From:

- People having to attend separate physical, mental health and social care services;
- Inconsistent focus on proactive care and support for self care;
- People having to travel un-necessarily for diagnostic and clinic based services;

  giving the same information many times.

To:

- Easy access to joined up physical, mental health and social care 'one stop ' services in a community setting where possible;
- Proactive care planning and better use of technology helping people to look after themselves, at home where possible, and benefit from shared information systems.

Planned Care - where are we now and what will be different?

The principles of well co-ordinated care, easily accessed and provided as near to home as appropriate apply equally to these services.

From:

Assessment & Treatment

- A 'traditional' outpatient model of multiple face-to-face visits for diagnostics and clinic based consultations with poor access to technology which would support better information sharing and models of care;
- Elective services largely delivered within the boundaries of acute hospitals, delivered by a traditional secondary care staffing model.
- Silo working between specialists and generalists (sometimes based on a 'doctor knows best' mentality striving to cure/fix particular 'body parts' instead of a whole person focus on the quality of life)

Diagnostics

- Diagnostics are not always readily accessible and results can often take a while to be returned to the GP Practice

Minor surgery

- Minor surgery is provided in some community settings.

Older Peoples' Community Mental Health (OPMH) / Community Dementia care services

- Insufficiently integrated with physical and social care in a community setting;
- Access to early diagnosis and rapid response services is inconsistent, outpatient model is a common mode for psychiatric medical delivery and embryonic memory assessment services;
- Traditional day care services do not always meet people's needs

Adult mental health

- Community and outpatient services delivered via recovery teams and traditional OPD model in localities
- Crisis and home treatment services focused more on urgent assessment than home treatment;
- Early interventions actively delivered in local teams and assertive outreach services part of recovery teams.

Other Planned Care

- There are additional services, commissioned by NHS England and Public Health (e.g. Health Visiting, Community Dental and Sexual Health) which also need to be taken into account; as well as voluntary agencies

Children's services

- Still operating separately on occasion meaning families are not getting a continuous service and having to make multiple visits and provide lots of the same information.

To:

Assessment & Treatment

- Available at times of the day which support 7 day a week care
- Outpatient clinics in community settings focusing on people rather than 'body parts'; creating supportive 'networks ' of specialists and generalists working together;
- Easy co-ordinated access to a one stop shop assessment and treatment service to avoid multiple visits
- Community nursing and other services providing care into the home will use community hubs as their base and for clinic based care such as dressings clinics

Diagnostics

- Diagnostic services, such as radiology and pathology, more accessible to community settings.

Minor surgery

- Minor surgery and some more complex procedures will be provided in suitable locations meeting the necessary standards across each community.

Older Peoples' Community Mental Health (OPMH) / Community Dementia care services

- Work together with voluntary sector and physical and social care services, including primary care and care homes, to deliver services in a community setting to ensure good transition between services, best skill mix and responsiveness;
- Offer mental health wellbeing, community reintegration, core mental health care assessment and early diagnosis, therapy support such as specialist OT, CBT and family interventions;
- Work jointly with our community support team services for frail elderly and with our learning disability service
- Focus on prevention, care and treatment and manage the transition between services
- Develop a rapid response dementia care team working with RMNs, specialist outreach, psychiatric liaison and Admiral Nurses
- Offer access to specialist inpatient beds for people with organic mental health and to a challenging behaviour unit at Ash Green
- Change day hospital support, working with voluntary care sector, to better meet people's needs

Adult mental health services

Recovery focused neighbourhood services prioritising wellbeing, close links with all community hub services and a seamless, ageless care model aligned to primary care.

Children's services (including school nursing and health visiting)

- Work increasingly closely with county council services and the voluntary sector as part of multi-agency teams
- Run clinic based services such as baby clinics, in community hub settings
- Midwives providing pre and post natal care may be based or run clinics from community hubs

All planned care services will work increasingly closely to promote health and wellbeing and work alongside these services

Urgent Care - where are we now and what will be different?

Community hubs will provide urgent care - responsive, effective and personalised services outside of hospital, in or as near to people's homes as possible for those people with urgent but non-life threatening needs.
Services will be linked to emergency care – delivered from centres with the best expertise and facilities for those people with more serious or life threatening conditions – typically in an acute hospital setting.

From:

Access

- In general, too many people still end up in A&E if they have an urgent but non life-threatening need. In 2013/14, 55% of the total A&E Attendances were at Chesterfield Royal, 16% attended the Minor Injuries Units (DCHS), 8% at Sherwood Forrest and 6% Stockport; with further 16% at other Providers. This split has remained fairly consistent over the past 3 years
- Urgent care is not generally well co-ordinated nor supported consistently by 7 day a week community and primary care services. This makes going to A&E the easiest option
- Safety, experience and clinical outcomes vary depending on the day of the week people receive care

Consistent response

- Within North Derbyshire there are currently 2 minor injury units at Buxton & Whitworth Hospitals with access to peripherals sites.
- Co-location of the MIU and GP Out of Hours (OOH) service in some locations at certain times has potential for duplication and confusion for people accessing these urgent care services; particularly where the OOH service offer a nurse-led urgent care walk-in facility on the same site as an MIU as is the case at Whitworth Hospital.
- Multiple offers and responses available when urgent care is required at different times
- People unnecessarily conveyed by ambulance to the Emergency Department..
- People with mental health needs not always treated appropriately, sometimes needing to receive care outside Derbyshire, because of a lack of community based crisis services.

Urgent care services outside of hospital

- Access to community and primary care services 7 days a week is inconsistent leading to people not always being looked after in the best place.
- Home visits by the GP OOH service have remained fairly static since 2011/12, however Clinician Advice and Primary Care Centre appointments have risen.

Emergency care

- Emergency care services are not currently well networked with other services.
- The Emergency Department at Chesterfield Royal is not well used over night.

To:

Community hubs will be part of a network of urgent care services so the overall system is more than just the sum of its parts. This will be through community hubs providing or supporting the following components of the urgent care service.

Access

- Easy co-ordinated access for to 24/7 physical, social and mental health services for service users and their families, helping people navigate the urgent and emergency care system to get the right advice in the right place, first time

Consistent response

- Better and more easily accessible information about self-treatment options the development of comprehensive and standardised care planning, so that important information about a people's conditions, their values and future wishes are known to relevant healthcare professionals.
- Developing the 111 service into a 24/7, personalised priority contact service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem;
- Expansion of community psychiatric nursing as part of 111 service to signpost people with mental health problems first time;
- Continuity with and consistency between in hours and out of hours services.

Urgent care services outside of hospital

- Faster and consistent same-day, 7day access to general practitioners, primary care and community services such as local mental health teams, community nurses, falls service and working with a range of other healthcare professionals including community pharmacists and ambulance paramedics.
- Those with urgent care needs treated in the most appropriate places with the expertise and facilities in order to maximise their chances of survival and a good recovery.

Emergency care

- Work to develop the appropriate emergency care service for those with serious or life threatening conditions in line with the Keogh Review and as part of a wider network of urgent and emergency services. The presence of senior clinicians seven days a week will be important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources.

Bedded Community Care - where are we now and what will be different

Currently, the lack of co-ordinated and proactive care in or near people's homes meaning too many people ending up in bedded care un-necessarily. Community services available 7 days a week in the right place co-ordinating access to locally provided and specialist provided beds when necessary.

From:

- A system which defaults to people being admitted to a bed.
- It is important to recognise the total bed capacity in the North Derbyshire Health and Care system; however it is the yellow boxes in the table which will be considered when developing future Community Hubs models.

Total number of beds in the system
Respite – 20 Social Care 10 existing, 10 planned
Dementia - 182 54 Long Term Dementia (46 existing, 8 planned) 53 OPMH (dementia) 12 Older Acute Functional Adult Mental Health 75 Dementia Friendly residential
Rehabilitation – 153 Including Reablement and Intermediate Care; 145 existing, 8 planned (social care)
End of Life Care 21 Hospice Beds
Acute Beds - 614 Includes 56 Adult Acute Mental Health beds at Hartington Unit
Residential Care 333 Extra Care Beds (269 existing, 64 planned) Excludes Private Nursing/ Residential Care Homes bed numbers

- Community care delivered in single site, single ward facilities.
- 'Bed based' rehabilitation model; reflecting the current beds but demand is already evidently reducing and will do so further with evolution of Integrated Care.
- Delayed Transfers of Care account for c.6% of bed days?
- An older people organic service that is dominated by bed provision
- Average length of stay for people with mental health needs at the Hartington Unit is 48.6 days
- Mental health referrals to acute mental health providers out of area leads to longer lengths of stay
- Mental Health Rehab beds provided solely from the Radbourne Unit based in Derby City.

To:

In future, bedded care will be more simply considered to be:

- **Locally provided** including (i) respite beds: typically to benefit the families / carers of those receiving physical, mental health or social care by providing overnight facilities; (ii) rehabilitation beds: provided when someone's needs are best met through provision of local bed based care, suitable for those with physical, mental health or social care needs. These will therefore include nursing home, residential home, Extracare and end of life care beds
- **Specialist provided**: those in acute hospitals such as Chesterfield Royal Hospital. These will not be a core part of a community hub but are included here given the need for community services to work closely with specialist services

- As the North Derbyshire Integrated Care model evolves and we develop community hubs ; we can anticipate a continued year on year reduction in the overall number of beds required, particularly specialist acute hospital and community hospital beds. However, we will continue to support growth in community and social capital through the enhancement of the proactive integrated care organised around local communities.

The beds which we do retain will be:

- Planned to meet the needs of our population and not reflect a historical buildings base;
- Planned and run in partnership across health and social care to support joined up care and the best use of our collective resources
- Part of an integrated network of care with the rest of the services available in the local community and supporting specialist inpatient services where necessary
- Provided in the right sort of environment which supports good quality care – this will mean they will be provided in fewer locations but be better supported by integrated community services
- Easily accessed by those receiving and referring for care, with clear access criteria, and effective onward care and discharge planning

Approach to developing Community Hubs

Successful delivery of the programme of work will require a comprehensive and coordinated approach. Building on this Strategic Outline Case, we will develop detailed options which are specific and appropriate to local communities.

The intention is to develop the models with our stakeholders and the public through wide scale engagement and involvement.

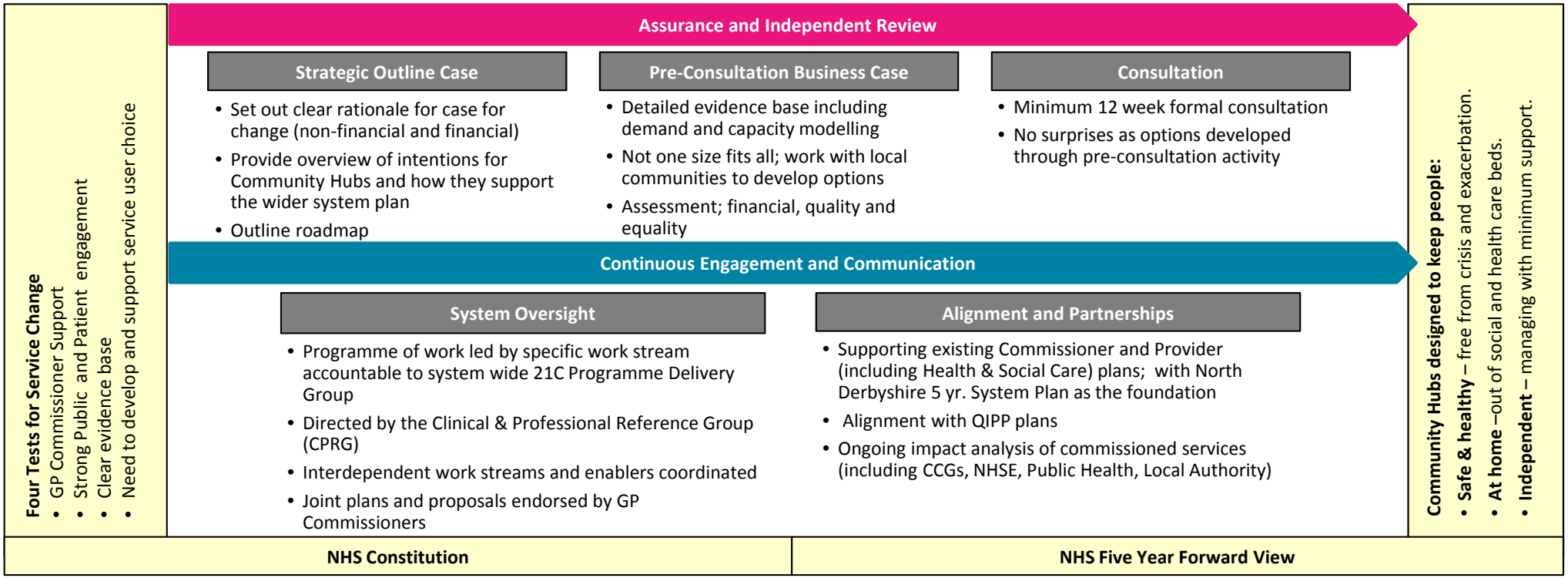
Although this document outlines some of the ways in which changes can be made; these will be subject to further discussion and development throughout the pre-consultation engagement period.

This approach to designing our community hubs will ensure that services are discussed with people; giving them the opportunity to influence the models. By providing people in local communities with an understanding of the system pressures and benefits that the wider changes will also bring, we will be 'telling the whole story' to help them make more informed choices.

The figure below summarises the process we will follow.

We will:

- Involve people prior to formal consultation, so that the models are developed based on what they tell us.
- Continue to ensure all views are captured in the final design during and after formal consultation.
- Recognise that the needs and situation of people varies significantly across North Derbyshire so 'not one size will fit all'.
- Work with 8 local communities to consider options which meet their specific needs.
- Ensure models designed demonstrate affordability, greater efficiencies , longer term viability and sustainability of services; whilst improving access, responsiveness, quality and support JoinedUpCare.



Outline timeline to develop Community Hubs

This timeline sets out the high level activities and milestones required to deliver the intentions set out in this Strategic Outline Case; in the way described in our approach (previous slide).

The process set out in this document will result in a consultation business case being prepared. The business case will not be taken to formal Boards until after the May 2015 General Election.

The process will be managed through an iterative approach ensuring ongoing feedback is captured and included alongside detailed development of the options. We recognise the interdependencies across the North Derbyshire System Plan; ongoing coordination of certain aspects will be required and oversight will be through the 21C Programme Delivery Group and CPRG.