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Developing a Strategic Service Model and Options for the Future Configuration of Provider Services for Herefordshire

A Report by the Health Services Management Centre and Crystal Blue Consulting

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Executive Summary

1.0 Scope of the review

Herefordshire Primary Care Trust (PCT), Hereford Hospitals NHS Trust (HHT) and Herefordshire Council commissioned the Health Services Management Centre (HSMC) to work with them in a strategic review that will *'ensure that provider services are fit for purpose and organised in sustainable configurations which are able to both drive service improvement and deliver real efficiency'.*

Crystal Blue Consulting was commissioned separately to work alongside HSMC providing support for economic analysis.

The review took place between March and September 2008and the principles underpinning the review were agreed between HHT, the PCT and the Council as

Delivering patient centred services
Support for a viable District General Hospital (DGH)
Delivery of clinically safe and quality services
Provision based upon integrated care pathways
Support for viable provider organisations

The review was cognisant of national and local policy and the strategic agenda to be addressed, specifically within the context of the NHS Next Stage Review. The review was to take into account services provided by:

- Herefordshire Primary Care Trust provider services
- General practice
- Hereford Hospitals NHS Trust (HHT)
- West Midlands Ambulance Trust
- Herefordshire Council Social Care Services
- Herefordshire voluntary sector providers

1.1 Process

The review had five distinct components, some of which took place concurrently:

- establishing review governance and project management arrangements

- the identification of those service areas for which to map models and pathways of care

- the development of a strategic model of care, including assessment of its current and future financial and clinical viability (via work to be undertaken by Crystal Blue Consulting)

- agreement of success criteria by which to measure the suitability and viability of potential provider configuration options

- the development of options and appraisal of these against the agreed criteria.

A Steering Group was established which included Chairs, senior executives from across HHT, the PCT, Herefordshire Council and General Practice. This met fortnightly during the review, acting both as a sounding board and as a decision-making forum. Two project managers were identified to lead arrangements across the organisations and to monitor progress. A wider Stakeholder Advisory Group was also established to support the option appraisal process.

2.0 Development of the Strategic Model of Care

Eight working groups based on the Darzi workstreams were established and asked to produce:

1. A description of the optimum future model of care for Herefordshire (using the National/West Midland Darzi vision as a starting point).
2. A summary of the evidence-base for the option.
3. A description of the difference between status-quo and optimum model in terms of how, where and by whom care is provided, and any impact on other services. Changes to be quantified as far as possible.
4. Barriers to implementation at the frontline and what needs to be done to overcome these.
5. Corporate and strategic requirements to deliver the new model of care

2.1 Progress

Working group progress to date has been mixed for a number of reasons. Membership of the working groups has not included all those required to make some of the decisions necessary, particularly clinicians. Additionally, key supporting services such as diagnostics and patient transport have been absent from discussions and therefore clarifying what is feasible to be delivered in alternative locations and community settings has not been possible. Social care managers and practitioners due to other constraints were unable to participate in most meetings so integrated social care planning and commissioning still needs to be worked in to the care models. The challenging timescale made it difficult for groups to meet regularly and with consistent membership. However, these issues are being addressed and the work is ongoing.

The review has demonstrated a real desire amongst the clinical and social care community to work together to achieve better outcomes for patients through improved co-ordination of care, greater integration and service efficiency. What has been achieved to date is a high level strategic direction summarised in Box 1.

Box 1: High level strategic model of care

- A move to a community-based model of care with in-reach to acute and centralised services where clinically appropriate and resource efficient. Each working group has identified areas of current care delivery that can either be expanded within the community or shifted from the hospital to a community setting. This includes some outpatient activity, diagnostics and services to promote health and wellbeing.
- Personalised, outcome-based care with high quality service delivery.
- Increasingly integrated health and social care services to support health, wellbeing and independence.
- Integrated care pathways that deliver care closer to home and make efficient use of acute services, maximising the expertise of generalists and specialists.
- Shift of care across the care continuum, repatriating tertiary and secondary care where appropriate, shifting care from hospital to community and supporting self care to reduce dependency on services.
- Developing community hospitals as a local resource for short term in patient care, active rehabilitation, outpatient clinics and fast access diagnostics.
- Local access to maternity, paediatric and accident and emergency services.
- Equitable access to services in each locality.

3.0 Understanding the geographical, service activity and financial context

Section 4 of the main report describes the baseline of Herefordshire's current funding and service provision across the PCT, social services and HHT, within the context of population and geography. The PCT spends £257 million on healthcare and a further £40 million is spent by the local authority on residential and domiciliary care. £34 million is spent on out of county acute care

Herefordshire's population of 180,000 is relatively old, with 20% aged 65+ compared to an England average of 16%. In the next five years there is projected net growth of 2%, but this is confined to the 65+ client group which will grow by 23%. Population density is low at 82 people per square kilometre compared to the England average of 380. HHT treats patients from Powys in the west, expanding the catchment population to up to 250,000. Geographical context is important because, even though the population is smaller than the 450-500,000 required to sustain an acute general hospital according to the Royal Colleges, without an acute hospital located in the county many residents would need to travel over an hour to a neighbouring hospital in Worcester, Gloucester or Abergavenny.

The shape of Herefordshire's service is linked to its geographical structure: hospital utilisation is lower than the England average, emergency admissions from A&E are lower than both the England and the West Midlands average, (consistent with a relatively low acute bed base), while residential care funded by social services is higher than a benchmark sample of local authorities. Primary care has traditionally managed patients that elsewhere might be hospitalised, indicated by relatively low referral rates, e.g. in paediatrics.

The PCT spent £257 million in 2007/8:

- 49% (£126m) on acute care with 26% (£69m) at HHT;
- out of the other £57m acute, £23m represents specialist tertiary services, leaving a total of £34m out of area acute;
- secondary acute therefore totals £93m;
- primary care comprises 24% (£62m);
- community care + mental health + learning disabilities comprises 24% (£62m);
- out of area treatment is mainly specialist acute services but it also includes £8m of mental health services.

The local authority spent £40 million on residential, nursing home and domiciliary care:

- £25m (63%) on residential home placements
- £7m (17%) on nursing home placements
- £8m (20%) on home-based or domiciliary caseloads

The largest single client group, in terms of expenditure, is the elderly with £17m on care home placements for 974 people and £5m on domiciliary care, totalling £22m or 56% of resources. Learning disabilities comprises 27% of spend (£10m) with 167 people placed in care homes.

Much of the quantitative focus of this provider review has been on the viability of acute services, given the twin pressures of (i) specialisation into larger hospital centres and (ii) migration of services closer to home, taking activity out of hospital into the community and primary care. This work is embryonic given the strategic model of care is not yet completed but clinically, the evidence to date suggests that acute services are sustainable with investment

in medical staff, e.g. in obstetrics. Sustainability may therefore be traded for resource efficiency or value for money. Underlying pressures for change have been identified as largely financial, in terms of (a) funding flows which make it difficult to transfer resources out of hospital into the community and (b) longer term difficulties likely to be experienced by HHT in accessing capital needed for future investment in acute services.

4.0 Options Appraisal

Building on a July workshop with the Stakeholder Advisory Group HSMC developed a list of success criteria based on the key principles underpinning the review (see Table 12, main report). Drawing on the input of the working groups and on interviews with key stakeholders, HSMC developed the list of options for future organisational configurations excluding children and mental health services (see Box 1, main report). It was agreed that these options would have significant implications for mental health and for children's services – and it was decided that these were so important that they needed to be addressed separately (rather than running the risk of failing to do them justice as part of more general discussions). Although 'do nothing' was retained as a potential option, as is customary in option appraisals, this had already effectively been ruled out by the Steering Group based on a collective view that remaining with the current organisational configuration was not sustainable in the long-term. (Note: options including general practice refer to provider representation of GPs within the formal governance structure)

4.1 Option Appraisal Outcome

There was significant consensus for the preferred options and also options that were not generally supported. The top three preferences expressed by workshop participants (in order of preference) were for:

1. A new integrated hospital, community health and adult social care organisation (Option 5).

2. A new integrated hospital, community health, adult social care and general practice organisation (Option 6).

3. Integrating general practice, community health care and social care, whilst also pursuing option 2a/2b for hospital care (Option 11).

Of the preferred three options, there was strong consensus from all groups about the desirability of Option 5, but more mixed views across different groups about Option 6. Participants identified a number of key themes that had helped to guide their thinking:

- There was strong consensus that doing nothing was not a credible option, and clear recognition that existing organisational structures were not necessarily the best way of delivering better outcomes for patients and service users.

- Participants were clear that any future option had to involve social care (and therefore tended to reject options that focused solely on health care).

- Participants stressed the need for a whole systems approach (and therefore tended to mark down or reject any option that seemed to be focusing on one part of the system in isolation or failing to tackle perceived inter-organisational barriers in the current system).

- Debates about organisational structures should not prevent ongoing and detailed work with regards to new service models (which should be agreed and implemented irrespective of future decisions about current organisations).

5.0 Conclusion and Recommendations

When this review was first commissioned and the process to deliver it discussed with the Steering Group, the scale of the task ahead in terms of developing a well articulated and a reasonably quantified strategic model of care with associated care pathways may not have been fully appreciated by many. While it was suggested that there was already a degree of clarity of direction around each of the Darzi workstreams, in practice while some strong pockets of discreet activity were underway, much had still to be initiated.

The first challenge for the groups was to assess the applicability of the West Midlands Darzi models to Herefordshire, and to commence the task not only of formulating a local vision but of providing the detail - in terms of resource requirements and activity shifts - that would enable the new model to be costed. The SHA-driven timescale to complete the review in six months was extremely tight which brought its own challenges for involving health and social care professionals. It required work on the care models to be given the highest priority by all organisations in terms of time and senior leadership.

The review has not progressed to an agreed preferred organisational option within the given timescale. This is mainly due to it coinciding with work required to meet the World Class Commissioning agenda creating competing priorities for senior management time, the appointment of two key senior staff during the review timescale and recognition that there was catching up to do in establishing the required strategic planning structures and processes that can deliver work of this nature effectively.

5.1 Case for organisational change

The strategic care planning process has not been completed and therefore it would be premature at this stage to conclude a case for organisational change. From work achieved to date, there is nothing to suggest that the desired service outcomes expressed by the working groups could not be achieved through the development of integrated care pathways and clinically integrated systems. As stated above, we know that structural solutions rarely

deliver the outcomes intended and the cost and other effects of major structural change need to be weighed very carefully against the expected long term benefit to the Herefordshire population. There is no appetite within the clinical community for major organisational change without a clear rationale and so to gain their co-operation and involvement the case for change needs to be very clear.

However, it can be argued that Herefordshire has other drivers which suggest the development of a new integrated organisation is worth exploring in more depth once care models are agreed and the impact of those on each organisation is understood:

- the local geography which requires sustaining essential hospital services
- the long term financial viability of a separate hospital Trust for the size of Herefordshire
- the long term viability of the PCT provider services within the current policy context to separate commissioning and provision
- the policy requirement for all NHS Trusts to become Foundation Trusts and the challenges this creates for a small DGH
- the historical culture within Herefordshire, expressed by many, of organisations operating as silos in service development and planning
- the outcome of the initial option appraisal to pursue an integrated organisational model

These factors should be considered alongside the economic and activity modelling when the pathways are fully established. Whilst each by themselves may not constitute a robust case for change, viewed as a whole picture the case for change may be stronger. It is important to remember however the lessons learnt from other major reconfigurations. There may be a temptation to shortcut the process of developing agreed care pathways, clear commissioning plans and ensuring clinical ownership of change across the whole clinical community and rely on a structural solution. However without achieving this clarity and consensus and having a robust rationale for change it will be much more challenging to deliver the desired improvements in health and social care to the population.

5.2 Recommendations

Our work supporting the review leads us to the following recommendations for ensuring that an appropriate way forward is found that will best meet the health and social care needs of Herefordshire people:

- To further strengthen and practically support the working groups to produce the care models at a level of detail that can ensure understanding of the whole system impacts and be costed to inform a case for change

- To appoint a project manager with the appropriate skill set and authority to lead the ongoing work of the working groups

- To establish a clear approach to commissioning that takes account of both the working groups and the newly-established clinical forum, and sustains and builds on the wider stakeholder engagement achieved through this project. A well-defined strategic planning structure informing commissioning will underpin not only the conclusions of the provider review but also the joint working/strategy development that needs to gather momentum

- To ensure that appropriate attention is given to the complex areas of mental health and children's services (not least child and adolescent mental health which is at the intersection of these two fields but can fall between them). There are existing integration issues to pursue in both these areas and the relationship of these to the aspiration for greater integration for other services need to be fully understood. A high level of commissioning leadership and support is likely to be needed to balance these different agendas.

- To reflect as a Steering Group upon the potential for integration to support the strategic model, seeking clarity as to the areas of care where integration has most to offer to Herefordshire people, and taking into account the pitfalls highlighted in the literature as set out above.

- To ensure greater involvement of wider stakeholders including the voluntary sector within the service planning process.

- Once the implications of the strategic model of care are clear the short-listed options described above should be developed in greater detail so that they can be more comprehensively assessed and subjected to the types of test set out in section 5.7 above alongside an objective financial assessment.

- To explore the potential of an integrated urgent care model for Herefordshire as a Department of Health pilot site

- If a case for change for organisational reconfiguration is agreed then work needs to be undertaken to identify the most appropriate organisational and governance model.

1. Background and Context

Herefordshire Primary Care Trust (PCT), Hereford Hospitals NHS Trust (HHT) and Herefordshire Council commissioned the Health Services Management Centre (HSMC) to work with them in a strategic review that will *'ensure that provider services are fit for purpose and organised in sustainable configurations which are able to both drive service improvement and deliver real efficiency'*

This was recognition that the present configuration of provider services appeared unsustainable in the long term, financially or clinically (see below for further discussion). Additionally, current health policy for establishing Foundation Trusts (FT) and the need for explicit separation between PCT commissioning and provider functions had led HHT and the PCT separately to explore other potential provider models (social enterprise and FT status) and there was recognition that further strategic work needed to be undertaken towards a whole system health and social care vision for future service delivery.

Crystal Blue Consulting was commissioned separately to work alongside HSMC providing support for economic analysis.

The review took place between March and September 2008. The principles underpinning the review were agreed between HHT, the PCT and the Council as:

- Delivering patient centred services
- Support for a viable District General Hospital (DGH)
- Delivery of clinically safe and quality services
- Provision based upon integrated care pathways
- Support for viable provider organisations

The review was cognisant of national and local policy and the strategic agenda to be addressed.

1.1 National and Local Context

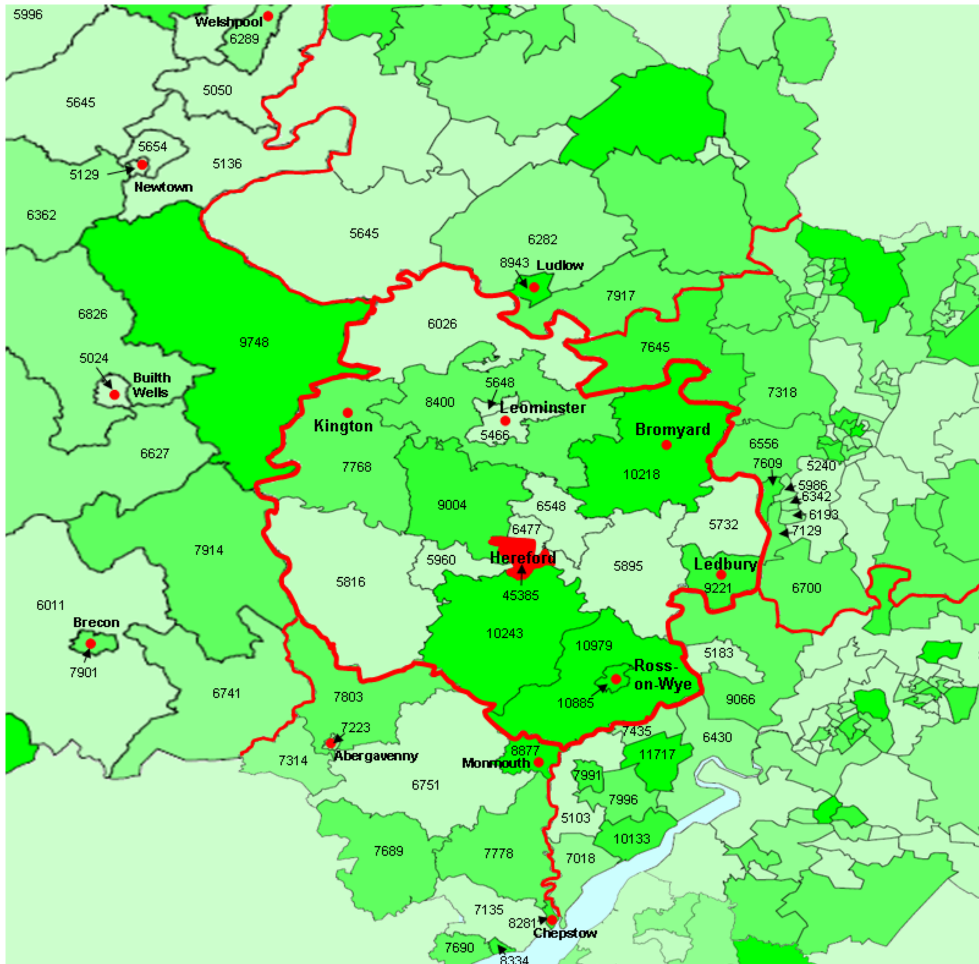
Local demographic context

The resident population of Herefordshire is estimated at nearly 180,000. The striking features of this population are:

- It is a relatively old population, with 20% aged 65+ compared to 16% in England;
- Moreover there is significant growth projected for the older population, posing increasing health care demands in the future supported by a smaller working age population. By 2013 a 26% rise is projected in the

number of people aged 85+, the group with the highest needs for health and social care;

- As the map below demonstrates it is a very rural county with few centres of population outside the city of Hereford. The density of population is low at 82 people per square kilometre. This is in contrast to a national average of 380 /km^2 and, at the extreme for England, Lambeth's density of 10,142 /km^2.



Source: ONS 2001 Census

These features, which are important factors in this review, are explored in more detail in section 4, alongside service and financial issues.

The political context

The review was cognisant of national and local policy and the strategic agenda to be addressed. Key factors included:

1. The regional work in relation to the Department of Health report *'Our NHS, Our Future'*[3]. Strategic Health Authority (SHA) working groups are developing pathways of care for the following eight areas: Maternity and Newborn, Children's Health, Staying Healthy, Long Term Conditions, Acute Care (urgent and emergency), Planned Care, Mental Health and End of Life Care.

2. '*Investing for Health*'[4], the West Midlands five year strategic framework for improving health and health services.

3. The need to demonstrate stronger commissioning of PCT provider services as outlined in *Commissioning a Patient-led NHS*[2]

4. The development of Practice- Based Commissioning

5. The requirement set out by the SHA for Local Health Economy Overarching Plans to 2012/13 which set out the key expected elements of strategic service plans

6. The postponement of the Wave 9 Foundation Trust application by HHT until the review has been completed

7. The ongoing development of the Country's first Public Service Trust, integrating the commissioning of the PCT and LA commissioning functions.

8. The demographics of Herefordshire as described above.

9. The shared boundary with Wales and the need to agree commissioning models and activity levels between Herefordshire PCT and Powys Local Health Board.

10. The PCT provision of mental health services

11. The impact of the European Working Time Directive (EWTD) on the delivery of acute care

12. The variance in the geographical, HHT and GP registered populations.

1.2 Scope of the review

The scope of the review was to take into account services provided by:

- Herefordshire Primary Care Trust provider services
- General Practice
- Hereford Hospitals NHS Trust (HHT)
- West Midlands Ambulance Trust
- Herefordshire Council Social Care Services
- Herefordshire voluntary sector providers

Review components and governance arrangements

The review had five distinct components, some of which took place concurrently:

- establishing review governance and project management arrangements

- the identification of those service areas for which to map models and pathways of care

- the development of a strategic model of care, including assessment of its current and future financial and clinical viability (via work to be undertaken by Crystal Blue Consulting)

- agreement of success criteria by which to measure the suitability and viability of potential provider configuration options

- the development of options and appraisal of these against the agreed criteria.

A Steering Group was established which included Chairs, senior executives from across HHT, the PCT, Herefordshire Council and General Practice. This met fortnightly during the review, acting both as a sounding board and as a decision-making forum. Membership of the group is attached at Appendix 1. Two project managers were identified to lead arrangements across the organisations and to monitor progress. A wider Stakeholder Advisory Group was also established to support the option appraisal process.

This report presents the outcome of each of the other components, and makes recommendations for future action as appropriate.

2. Development of the Strategic Care Model

Developing a strategic care model that provides a robust narrative of future service delivery was agreed as a crucial pre-cursor to undertaking a Provider review. Whilst small pockets of work were being undertaken by various groups within individual organisations and between consultants and GPs in clinical areas such as COPD there was no existing whole system strategic planning structure on which to build. Therefore working groups were established based on the Darzi care groups to develop and agree care pathways across health and social care.

2.1 Darzi-based working groups

Each of the 8 working groups were asked to produce a report that included:

6. A description of the optimum future model of care for Herefordshire (using the National/West Midland Darzi vision as a starting point).
7. A summary of the evidence-base for the option.
8. A description of the difference between status-quo and optimum model in terms of how, where and by whom care is provided, and any impact on other services. Changes to be quantified as far as possible.
9. Barriers to implementation at the frontline and what needs to be done to overcome these.
10. Corporate and strategic requirements to deliver the new model of care

Each working group was assigned a Director-level lead to provide leadership and take responsibility for delivery. HSMC facilitated a workshop for each working group to enable it to establish a baseline of current service developments and identify what further work was necessary. The timescale for delivery was acknowledged as challenging with the added factor of summer holidays.

A further workshop was held in July for all the working groups to share their progress and allow other groups to comment and observe where there may be duplication or gaps in development.

Progress

Working group progress to date has been mixed for a number of reasons and a summary of the working group reports from the July workshop are in Section 3. Membership of the working groups has not included all those required to make some of the decisions necessary, particularly clinicians. Additionally, key supporting services such as diagnostics and patient transport have been absent from discussions and therefore clarifying what is feasible to be delivered in alternative locations and in community settings has not been possible. Social care managers and practitioners due to other constraints were unable to participate in most meetings so integrated social care planning

and commissioning still needs to be worked in to the care models. The challenging timescale made it difficult for groups to meet regularly and with consistent membership, and strong third sector and user and carer involvement is yet to be achieved.

These issues are now being addressed in each working group and the working groups have nevertheless made significant progress in reviewing existing care delivery and identifying where changes need to be made to meet population needs, clinical standards and policy imperatives. What has been achieved to date is a high level strategic direction. This can be summarised as:

- A move to a community-based model of care with in-reach to acute and centralised services where clinically appropriate and resource efficient. Each working group has identified areas of current care delivery that can either be expanded within the community or shifted from the hospital to a community setting. This includes some outpatient activity, diagnostics and services to promote health and wellbeing.

- Personalised, outcome-based care with high quality service delivery.

- Increasingly integrated health and social care services to support health, wellbeing and independence.

- Integrated care pathways that deliver care closer to home and make efficient use of acute services, maximising the expertise of generalists and specialists.

- Shift of care across the care continuum, repatriating tertiary and secondary care where appropriate, shifting care from hospital to community and supporting self care to reduce dependency on services.

- Developing community hospitals as a local resource for short term in patient care, active rehabilitation, outpatient clinics and fast access diagnostics.

- Local access to maternity, paediatric and accident and emergency services.

- Equitable access to services in each locality.

The commissioning team are now working alongside the work groups to ensure agreed developments feed in appropriately to commissioning plans.

It is recommended that the working groups are sustained and supported practically, e.g. by the provision of relevant data, until there is sufficient detail available about the future care models to enable the activity and financial consequences of these to be established.

2.2 New ways of working across key delivery areas

To support the delivery of the care models additional strategic direction work has been undertaken to redesign key delivery areas that cut across the Darzi-based workstreams (but are consistent with them), building on work which was already underway before the review commenced. To support this work, a clinical forum of Consultants from HHT and GPs was held in August to facilitate a shared vision of future service delivery, gain a senior clinical contribution to developing models of care and provide opportunity to further develop clinical working relationships. (A report from this forum is attached to this report at Appendix 2). Work focussed around the following key areas:

Locality- based multi-disciplinary teams

Proposals to develop integrated teams of health and social care practitioners based on practice populations had begun before the review but are now seen as a key enabler to delivering the care models. Bringing together health and social care provision and devolving the management of resources to team level is seen as the optimum way to ensure greater integration and joint ownership of patient and service outcomes.

This is a model of care that is well developed in some parts of the country and there is some evidence that it produces effective outcomes. Perhaps most well known is are the integrated teams that have been developed over a number of years in Sedgefield, County Durham with health and social care teams operating under a single budget and management system (Hudson 2005, 2006).

Developing the role of community hospitals

The community hospitals are seen as a rich resource within the County but are not used efficiently. Delayed discharges for some patients are largely a result of social care resource constraints (staff, funding and available care home beds) that prevent discharge back home or to residential care. However, this is resulting in blocks in other parts of the system, most importantly in HHT's ability to transfer people back to a community setting in a timely manner.

There is a consensus from the GPs and Consultants that the key roles of the hospitals should be as follows:

- 24/7 short term step-up in-patient care when acute hospital care is unnecessary
- 24/7 step-down rehabilitation to ensure timely transfer from HCH beds to the community
- Outpatients where there is sufficient critical mass to justify clinics.
- Day case treatment.
- Urgent Care.
- Maternity care
- Palliative Care

- Diagnostics (X-ray and Ultrasound)
- Specialised Stroke rehabilitation potentially creating a specialist unit in one hospital.

It was agreed that there is still much work to do as part of the ongoing strategic planning process/working group deliberations in mapping current and future activity to inform exactly what services will be provided in the community hospitals. It was agreed that this work needed to be undertaken as part of the practice-based commissioning development and within the framework of an established strategic planning structure (see below).

Integrating urgent care

The clinical forum endorsed previous work to create an integrated primary and secondary care service in A&E. There was a very strong consensus that it was crucial to ensure services remain on the hospital site due to the local geography but also because of the impact losing the Department would have on the viability of other services within the hospital.

This would involve a front door triage, directing patients to appropriate primary or secondary care facilities. Creation of a Clinical Decisions Unit with rapid access to diagnostics would reduce the need for unnecessary admissions. Patients could be 'fast tracked' to clinics as part of primary and secondary care pathways from the Department.

3. Emerging Care Models

Outlined below is a summary from each working group report produced in July that describes the general direction of travel and at the time of the report some working groups have already done further work. Each group have begun to identify the care provided in each care setting and are being tasked to work up the care pathways in more detail that will allow for quantification of the changes made and an impact analysis on infrastructure, supporting services, workforce and long term sustainability.

Maternity and Newborn

Pre-conception
A continued emphasis on sex/relationship education for all appropriate age groups and pro-active preventative work for all – including teenagers.

Pregnancy testing
Free pregnancy testing at a range of outlets supported by quick and easy access to midwives through a universal booking system. Early GP notification.

Ante-natal
Teams of midwives (and others) supporting continuity of care. Midwives providing a screening and health promotion role but also other professionals such as Practice Nurses working with women throughout pregnancy as they would work with any practice patients. Early identification and management of high risk patients and early identification and management of low risk patients will enable increased choice and an effective shift into community based care.

Unwanted pregnancy
More work with teenagers and others to reduce numbers of terminations

Delivery
Increase in choice and in home births. Potential for midwifery-led unit backed up by co-located obstetric unit. Work to decrease in C-section.

Neonatal
Special care outreach service and support at home will enable greater choice and will provide more efficient management of cots for local people as often babies and/or women in labour, have to be transported elsewhere because of capacity not capability to care. Retain neo-natal network at HHT. Breast feeding sustainable support- adoption of the UNICEF Baby Friendly Initiative by both hospital and community midwives. Therapy input into infants on NICU/SCBU

Post natal care
Children's Centres and other community establishments should be used for ante natal and post natal support where the space is fit for purpose.

Children and Family Services

Universal
Emphasis on shared information and care co-ordination.
Health promotion at all levels and age groups
Ensuring community based facilities are well used and are 'fit for purpose'

One NHS number to identify services users – there can be confusion over surname for newborn and leading to more than one number being issued

Targeted
Improved safeguarding by greater understanding of need (working with Mental Health, drug services etc)
Child protection training and assessments need to be improved, along with required family support
Increase access in community to child-friendly OOH services that would prevent unnecessary admission
Improve the quality of services for adolescents with the appointment of an adolescent 'champion' charged to ensure flexible, responsive and targeted services in fit for purpose facilities. Particular focus on mental health, eating disorders, head injury. Attention given to parenting support and to workforce development. Young people friendly gold standard services
Greater access to confidential adolescence services – extension of 4us services
Targeted support for excluded children and for hard to reach groups
Locally based management of children with long term conditions
CAMHS move away from one size fits all into a flexible responsive and child friendly service
Role of school nurses/community workers etc in making contact with vulnerable children-prevention re DNAs

Specialist
Increase in therapy for children with disabilities; investment in community services
Increased investment in community paediatric nurses; enabling hospital at home and earlier discharge
Involving third sector at a specialist level – to enable sustainability of support
Rapid assessment in A&E and ward to prevent unnecessary admission, especially of OOH children. Appropriate clerking routines.
Specialist staff working together in the Assessment Unit
Improved local palliative care; increase in community paediatrics

Tertiary specialist
Maintain and increase clinical networking (oncology and child protection as particular issues) to improve quality and to avoid unnecessary out of county placements
Ensure specialist services (e.g. cardiology, echo-cardiography) are sustainable

Staying Healthy and Independent

Obesity - primary prevention pathway. Potential expansion of peer support model currently used in South Wye Breast Feeding project
GP services: provision of advice and support for weight management and weight gain prevention
Raise awareness of obesogenic environment: develop a more physically active culture through environmental planning, play provision, employers as role models, use of local champions and healthy eating policies in institutions, public buildings and workplace canteens

Smoking cessation: improved socio-demographic information and staff training in social marketing. Stop smoking education needs to be non-judgemental and focus on health and non-health benefits of quitting - financial etc. Explore the introduction of incentives for quitters

Sexual health: increased capacity including training co-ordinator to train GPs and others for brief interventions. Sexual health 'normalised' through integration and delivery with other services. Positive selling - connecting with young people in appropriate ways: access for all appropriate to rural county

Alcohol service not visible - improve quality of leaflets etc and communicate range of services that are available more effectively. Awareness campaign: education involving all

relevant partners from primary school right through. Provide information to empower personal responsibility. Seamless care pathway for people with a drink problem regardless of how they are identified - multi-sectoral, holistic approach

Focus on psychological well-being Community /psychological well being/ mental health services more accessible. Increased capacity of early intervention mental health teams: address waiting times. Improve partnership working across all sectors: health still dominates with 'medical' model

Introduce systematic completion of health (inequalities) impact assessments on all commissioning proposals.
Commission an enhanced Health Trainer Service to meet the West Midlands SHA recommendation
Look for ways in which the Third Sector can work more closely together without losing local ownership and impact

Long Term Conditions

Prevalence of long-term conditions in Herefordshire
Joint needs assessment needed to establish what are the 10 most prevalent LTC in the patch. Based on the West Midlands model, the working group proposes the following generic model for Herefordshire:

Population prevention
A key objective of the strategy is to shift the emphasis to prevention. Proposal is for deliberate positive social marketing for Herefordshire and neighbours; a positive, non-judgmental approach using the same language as the public.

Early assessment and diagnosis
A proactive approach adopting a consistent approach to profiling and predicting (PARR/Dr Foster). Encourage GPs and Advanced Practitioners to increase early screening in primary care. Clearly defined, agreed and owned pathways that go across all sectors of care.
Coherent social base programme to support health. Improve consistency of referrals
More individualised approach:

Single assessment process/one stop shop; clear, accurate information
Single record, supported by IT developments
“Family” is as defined by customer; basic social need acknowledged
Refocus pharmacy

Ongoing care: self care and self-management, secondary prevention
Herefordshire Direct: Single point of contact for public, service users, carers, voluntary sector and professionals offering comprehensive and up-to-date database of services and resources, skilled and consistent signposting service. Web-based and telephone service. This can be created by building upon current arrangements across agencies.
(insert Herefordshire Direct diagram)
Self-management – skill up patient groups for mutual support and individuals to self care. Use of individual budgets to enhance personal responsibility.
Care at home or locally where possible: Involve third sector organisations where possible.
Near patient/home testing
Mobile unit for rural areas
Use community venues for patient groups (schools, community hospitals)
Use of wellbeing coordinator and care coordinator as LTC issues change. Model of care coordination needs to be selected and implemented.

Single team approach: outpatients, acute and intermediate care
Knowing the population/systems for recall and review
Information sharing across the whole pathway
Reduce the amount of long-term care provided in secondary care

Reduce admissions (in which types of case/speciality etc: implications for community nursing?)
Increase number of Emergency Practitioners to 9 (from how many?)
Very specialist care should take place in specialist units.
Rehabilitation
Therapy input to intermediate care and community rehabilitation for users who fall outside intermediate care criteria. Role of assistive technology in speeding up discharge/increasing independence. Helping people get back to work (pathways to work programme by Job Centre Plus), direct payments. Implement housing reviews

Planned Care

Self Assessment

This was felt to be too variable and unpredictable, also little evidence – should be looked at by another workgroup. Those requiring a planned intervention should be assessed by a health professional quickly.

Better access to diagnosis and treatment

Pre-referral diagnostics: GPs should be enabled to schedule more diagnostic tests before referral. Need to increase advice from secondary care on what to do by agreeing more specific care pathways, helping to avoid unnecessary referral. To achieve this requires:

- Faster access to diagnostics ie within 24 or 48 hours (requires investment); diagnostics on a one stop shop basis where care pathways allow.
- Improved communication and education between primary and secondary care, including provision of *advice* to GPs and constructive feedback on referrals. The timing and nature of some of these communications should be set out in care pathways.
- Using the intranet/internet more for accessing referral criteria and advice on referring, information on the likely post-operative effects of different operations/recovery rehabilitation issues so that GPs can discuss practical issues with patients. This may simply be a joint primary-secondary care agreement on which existing information on the internet is suitable. Improved paperless communication systems needed.
- Avoiding referral if the ultimate outcome is likely to be conservative management of the patient – ask the patient what they want at the outset.

More pre-assessment for surgery– if significant risk then don't refer.
Improve the Choose and Book system to allow GPs to refer to named consultants not specialities. Generic referral doesn't take into account the increasing sub-specialisation in medicine.

Streamlined secondary care consultations and care closer to home

- Increase the number of one-stop-shop clinics where a consultation is scheduled with the appropriate diagnostics to hand.
- Decide what pre-assessment is needed at one stop clinic via an initial screen by support worker. Pre-assessment can take place at outpatient appointment, GP practice (by practice-based OT), or by community re-enablement team.
- Decide whether treatment is day case or inpatient at the one-stop clinic.
- Decentralise outpatients: based on population density, outpatient clinics should be provided in Leominster, Ledbury and Ross. Constraints on the decentralisation of outpatient services are critical mass, the 18 week care pathway and sub-specialisation.
- Copy correspondence between secondary and primary care to the patient for information.

review of the secondary care portfolio and tertiary care provision to ensure best quality care, close to home where possible

NHS Herefordshire should undertake a service by service review of HHT's service portfolio focusing on the following questions:

- What tertiary services could be repatriated in whole or in part from Birmingham?
- Is Birmingham the best tertiary care partner – what other options are there?
- How should HHT's secondary services portfolio respond to the challenges in *Investing for Health* to 'vulnerable' specialties (emergency surgery, A&E, paediatrics and obstetrics), the size of HHT's catchment population, subspecialisation, training and EWTD issues etc?

Increase day case surgery

- There are opportunities to increase then level of day surgery/day care (eg gastro-enterology) by targeting specific procedures and by developing improved arrangements for post operative care eg
    - Outreach team
    - Intermediate care inreach
    - Patient hotel
    - Use of community hospitals
    - Social care.
- Audit and benchmark current practice and share results with clinicians – learn from best practice.
- Better scheduling of patients would increase day case rates – patients last on an afternoon list will very likely need to stay in overnight. HHT's day surgery unit's productivity could be improved through a mixture of improved forward planning (patient selection) and changes in consultants' job plans to dedicate mornings to surgery.
- Patients should be told about what the day surgery pathway involves and encouraged to make appropriate provision for managing at home in advance.
- In view of the benefits to be derived from separately streaming 1) elective and emergency patients and 2) day case patients and inpatients, consideration should be given to the creation of a dedicated day case unit within the County Hospital.
- Mobile day surgery serving a relatively small catchment population presents significant logistical, governance and financial issues which are likely to frustrate its introduction locally.
- HHT starts from a relatively high baseline of day surgery.

Coordinate discharge planning

- Ensure an assessment of discharge needs has been completed before admission, including social needs.
- Create a co-ordination role to case manage the patient through the planned care pathway.

Acute Care

Vertical integration of acute care services is required and we must create pathways that are clear to the patient that segment them appropriately to the correct services

Overview of what is required

- Access to 24/7 services – primary, secondary and social care with a broad suite of diagnostics available
- Single point of contact for the patient – either walk in or on the telephone
- Appropriate and timely assessment wherever and whenever the patient accesses services
- A pathway that is intuitive and easy to access
- Local triage by a health professional

- Access to a multi-agency care record
- Access to transport services
- Signposting a range of appropriate services
- Ability to refer to any to any acute service from any part of the pathway by any agency if appropriate

What does an integrated service look like?

Accessed by either walk-in (face-to-face) or telephone line with triage completed by a health professional (GP). A range of services that can be accessed directly:

Primary Care
- Urgent appointments in-hours at local surgeries
- Home visits by GP/Nurse/Emergency Care Practitioner (WM Ambulance Service)

Intermediate Care
- Rapid Response Team consisting of nurse, physiotherapist, OT and social services

Urgent Care Centre
- Primary care focus co-located with emergency care facility
- Staffed by Emergency Care Practitioners with knowledge of local patch and range of services available, which may be different in and out of hours
- Range of diagnostics available
- Access to all patient records
- Operational, HR and governance links to the Emergency Room (see below)
- Based in Hereford (preferably on HHT site in order to access advice, diagnostics etc.), and possibly at Ross and Leominster (if population warranted) with access to x-ray facilities.

Minor Injury Units
How do these feature in the model?

Emergency Care
- A&E / Emergency Room for the acutely ill requiring immediate treatment (target wait of 2 hours)
- A range of urgent outpatient appointments
- Clinical Decision Unit (CDU) - potentially able to reduce emergency admissions by 10-20%

Back into the community support options
Choices based on an agreed and formalised menu of services with agreed protocols for 'signposting' patients, including resources such as:
- Social care
- Residential/nursing home
- Housing department
- Assistive technology/telecare

Transport
- 24/7 patient transport services to ensure the patient is in the most appropriate care setting, whether at home or in hospital.

Possible initiatives to undertake (jointly across HHT, PCT, Social services)
- Project to audit, identify and address 'frequent flyers' attending A&E
- Local telephone-based helpline (888)

Service directory to educate patients on acute service system

Mental Health

1. Children's Services – a specialist integrated service 24/7

The vision is for a model of care which:

- Emphasises building resilience in **all** young people
- Supports people in services already used through greater CAMHS input to universal services
- Prioritises early intervention: picking up families and young people prior to the problem escalating
- Offers a single point of access

Children, young people and families will supported where possible by universal services and third sector initiatives, but have access to a range of specialist inputs from an integrated CAMHS (health, education, social care), addressing mental health and behaviour issues including:

Post-traumatic stress disorder
Psychoses
Eating disorders
Personality disorder
Self harm
Anxiety
Depression
OLD
Attention deficit hyperactivity disorder (ADHD)
Autistic spectrum disorders
Conduct disorder.

The emphasis in addressing behavioural issues will be upon achieving better outcomes for the child, and supporting parents and professionals, rather than emphasising achieving a diagnosis. CAMHS will provide strong liaison into acute services via a mental health link worker for A&E/Paediatric ward.

Three distinct initiatives are envisaged:

Develop CAMHS role in Children's Centres for children 0 - 12: Bringing CAMHS input to the emerging Children's Centres, raising awareness, training and supporting the universal services workers from health, education and social care, providing input to parenting groups/courses, promoting a shift in emphasis from monitoring parenting to enabling parenting, offering some service out of normal hours.
Increase awareness and ease access to services for children 11 – 16 through extension of the Info Zone initiative in secondary schools: young people and parents would be able to access health promotion, service information and CAMHS support via the Zones. The Zones would need to be open morning, lunchtime and evening so that young people could go there without having to ask a teacher's permission.
Develop a young people service 14 – 25 years: This service will enable CAMHS to be delivered in a young people friendly way and increase ease of joint working with education, youth services and other young people's community services. This service will be achieved through pooling some resource between existing CAMHS and adult mental health services (see Diagram 2 in Appendix 1).

2. Adults of working age 25 - 64

The vision is for a Population Health Approach, offering 24/7 continuity of care across:
Age
Services – health and social care partners
Course of problem
Range of problems

Range of services and options with a choice in a stepped care model – from prevention to intervention using prevention, early identification and intervention within a: multi-agency & multi-access approach. Staffed by: a well-trained range of professionals who are welcoming, engaging, optimistic, reactive, responsive, flexible, and resourced and supported with ongoing education – positive about and promoting mental health. In modern facilities, with input to a range of other agencies in all parts of the county. Or own home or preferred location – with a choice. To include rapid access to specialist and tertiary services based on detailed assessment of need and facilitated moving on/progression.

3. Older People Mental Health & Wellbeing

The proposal is to operate a Herefordshire-specific West Midlands dementia pathway and also to provide a distinct functional mental health service. This builds on the current 2008 Service. The vision is for integrated services which incorporate the following:

Community services for start of pathway

- Joining community services to make a 23hr "hub" for advice and signposting – incl. Alzheimer's, Age Concern, village wardens, signposting scheme
- Telephone and local access points > early detection and intervention

Referral process – memory clinics and assessment
Hospital services – psychiatric liaison (2 –way process DGH > MH service
Specialist residential/nursing home care provision
Supported housing – lifelong
Modernised in-patient service
Transport
Carer support
Psychological support

The service would offer increased capacity for demographic change, personalisation, open access and choice, specialist support to wide range of generic support services and help to people in managing their condition and remaining independent (telecare, adaptations)

Functional Illness
(specialist separate in-patient unit planned)
Develop assessment and therapies and include trained professionals in resource centre, home or other environment.

End of Life Care

Currently, we do not have an agreed "End of Life Care Model" in Herefordshire, however, there is a "Palliative Care Strategy" which includes end of life care and there is agreement that more adults than currently do would wish to die at home. A shift to strengthen care in the community is therefore required.

However, it is also recognised that a proportion of deaths are always going to take place in other settings, such as the acute trust, community hospitals, care homes and the hospice, therefore standards of end of life care are needed for all settings.

The model for end of life care in Herefordshire therefore needs to be agreed following publication of the End of Life Strategy but at this time the proposed model / pathway for end of life care is based on the seven steps used in the West Midlands proposed pathway. These are:

1. Being informed about choices

Developing better information materials was noted as essential and an area that requires improvement. It is important to see this information as needed throughout life – 'we are all going to die' with the inclusion of end of life messages in health awareness campaigns. The '*Staying fit and healthy'* work stream could have a role to play.
In addition, information about what medical treatments can achieve is required so that patients are not actively treated inappropriately or are not denied the option of active treatment for a reversible complication.

But care must be taken not to raise public expectation of choices before systems and resources are in place to actually deliver on the choices. Information about choice of preferred place of terminal care should include a realistic description of services available in each setting, and the pros and cons of care in each setting, so an informed preference can be made by the patient, and with regard to their carers and family.

Acknowledgment that preference can change depending on the situation (e.g. challenging symptoms), and that given resources are not unlimited, meaning that preference is not possible for all people. But the aim should be to enable as many people as possible to die in the place of their final choice (i.e. the choice made closest to their death).

2. Discussing end-of-life wishes

Health and social care professionals need to feel confident that they can and should discuss end of life issues with patients and their carers

Establishing communication skills training sessions for all staff, not only those who have a specific remit for care of the dying was seen as essential because end of life care can become the responsibility of a diverse range of professionals across the health and social care community and because we wish to ensure
flexible skills within the system. This training needs to be mandatory. In addition, patients in Herefordshire have requested access to psychological services much earlier in the pathway. This will require additional resources.

3. Assessing need and planning care

Assessment of the physical, psychological, spiritual and social needs and wishes of the patient to ensure these are carried out wherever possible will be crucial to ensure choice. This information must be recorded and with the patient's permission shared with family and carers. This information will need to "travel" with the patient and / or be available to care givers across health and social care to ensure the wishes of the patient can be carried out. This requires shared information systems with a record of clinical details and preferred place of care and death if known.

4. Co-ordinating care

The work of health, social care and the voluntary sector must be better linked. One point of contact is needed for patients, families, and professional carers with one coordination centre to ensure help is organised quickly in and out of hours. Some have suggested St Michael's Hospice would be the ideal centre for this.

With regard to hospital services, the new "Supportive Care Nurse Specialist" post in Hereford County Hospital could ensure rapid assessment of patients registered on Gold Standards Framework general practice registers to assist with more timely and better planned discharge. Shared clinical information systems are again required to enable this co-ordination.

5. Organisations working together

A range of services are required 24/7. These include: qualified nursing care, personal care, night sitting, housekeeping, meals, transport and access to drugs and equipment. This is particularly challenging for Herefordshire because of the rural nature of the county and the difficulty finding carers. Flexibility and immediate response are essential features. Proposals should include the development of a shared care service, including a rapid response element with one point of access as outlined above.

6. Last days of life

A person's last days of life need to be made as comfortable as possible and ideally in the place of their choice. The patient's preferred place of care should already be known but we need to become better at documenting this earlier on. Comfortable transport needs to be available 24/7 to enable preferred place of care to be achieved. I.e. transfer from hospital / hospice to home to die. The End of Life Care Pathway needs implementation in the community and further embedding in each care setting to ensure sustained changes in practice.

7. Care after death

The body will be treated in ways that respect religious and cultural beliefs. Those close to the person who has died will continue to be cared for after death and in the following weeks and months if needed. Bereavement services need review in each care setting and across organisations as being led by St Michael's. Herefordshire needs a bereavement strategy.

4. Understanding the geographical, service activity and financial context

This chapter summarises activity and financial resource data that is detailed more fully in a separate technical supplement developed by Crystal Blue Consulting. Data has been collected according to the dimensions below.

Data Type	Sector	Service Area:
• Population • £ finance • workforce • service: patient activity, beds	• PCT • Hereford Hospital NHS Trust • Social Services	• Hospital Community, Primary Care, Social Services
		Group Care Area: • Maternity and newborn • Childrens' health • Staying healthy • Long term conditions • Urgent and emergency care • Planned care • Mental health • End of life care (Liverpool 'gold standard') • Long term residential care

4.1 Population

Herefordshire has a resident population of 180,000 across six localities, with 40% based in Hereford City. The age profile shows a relatively old population, with 20% aged 65+ compared to 16% in England, ranging from 17% in the City to 23% in the rural locality.

Table 1: Population 2008

Age band	Locality - Ross	Locality - City	Locality - Bromyard/ Ledbury	Locality - Rural	Locality - Leominster	Total	%
0-14	2,687	12,488	4,477	4,913	4,004	28,569	16%
15-64	11,388	48,727	18,150	19,980	16,382	114,627	64%
65+	3,933	12,968	6,486	7,262	5,792	36,441	20%
Total	18,008	74,183	29,113	32,155	26,178	179,637	100%
%	10%	41%	16%	18%	15%	100%	

Table 2: % in Age Groups 2008

Age band	Locality - Ross	Locality - City	Locality - Bromyard/ Ledbury	Locality – Rural	Locality - Leominster	Total	%
0-14	15%	17%	15%	15%	15%	16%	16%
15-64	63%	66%	62%	62%	63%	64%	64%
65+	22%	17%	22%	23%	22%	20%	20%
Total	100%	100%	100%	100%	100%	100%	100%

There is 2% growth anticipated across the whole population, but this is confined to the 65+ age group. The working age and child population will reduce. The implication is increased demand for health and social care and a reduced supply of labour in the future.

Table 3: Change in Population 2008 - 2013

Age band)	2008	2013	
0 - 4	8,696	8,700	+ 0%
5 - 14	19,873	18,900	- 5%
15 - 44	63,583	57,700	- 9%
45 - 64	51,044	53,900	+ 6%
65 - 74	18,842	24,300	+ 29%
75 - 84	12,739	14,400	+ 13%
85 +	4,860	6,100	+ 26%
Total	179,637	184,000	+ 2%
	100%	100%	

Age band	Total
0-14	- 3%
15-64	- 3%
65+	+ 23%
Total	+ 2%

4.2 Geography and Patient Flows

Herefordshire's 180,000 population is spread across a wide rural area, with average density of 82 people per square kilometre, compared to 380 in England and over 10,000 in parts of inner London. Rurality increases to the west and patients flow from Powys, (density 25 people per square kilometre), expanding HHT's catchment population by 18% to up to 225,000. On the other hand, 18% of Herefordshire PCT patients are treated in hospitals outside the county, so there appears to be no net cross boundary inflow.

The rural spread means that the nearest neighbouring hospitals are located in:

- Worcester 27 miles
- Gloucester 32 miles
- Abergavenny 24 miles

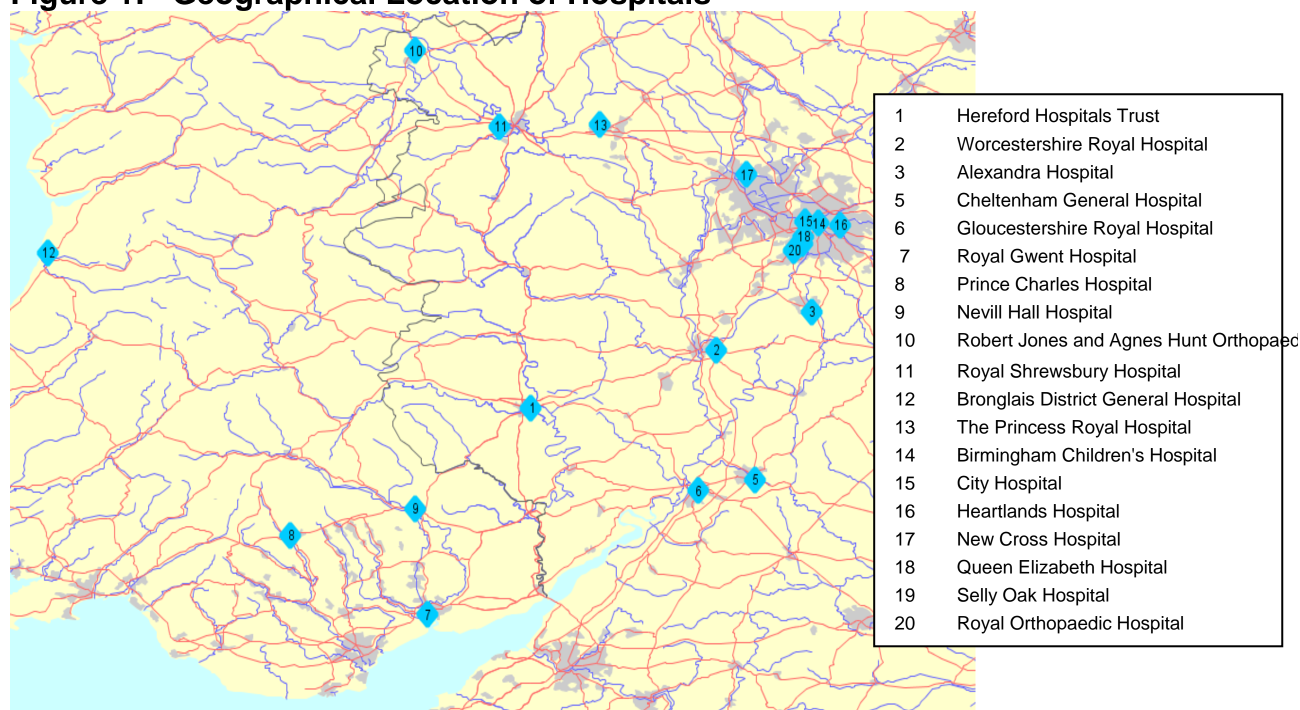
To the west there is no hospital between Hereford and Llandrindod Wells (Powys) and beyond, 40 miles distant, illustrated in the graph below.

Residents to the east of Hereford City have access to Hereford County Hospital (provided by HHT), Worcestershire Royal Hospital and Gloucestershire Hospital within the 'golden hour' time to treatment of 60

minutes[1]. Residents to the west of Hereford, including Powys, depend upon HHT for hospital access within an hour.

Royal Colleges suggest that a population base of 450,000 - 500,000 is required to sustain an acute general hospital[2]. Rural isolation therefore throws up a tension between being a small centre of population and requiring local access to acute services.

Figure 1: Geographical Location of Hospitals[3]



The geographical isolation is highlighted by ambulance journey patterns. According to ambulance officials who were interviewed, nearly all emergencies in the HHT catchment area go to Hereford County Hospital, with few diversions. (Worcester is used for patients in the east, e.g. the Bromyard area, due to proximity, but these are not classed as diversions). Air ambulance (helicopter) is staffed 7am – sunset, seven days a week, to transport major trauma to appropriate centres, e.g. Birmingham. 'The lay of the land' means that HHT is the only suitable destination for acute patients in the area. There is relatively little choice.

[1] 'Golden hour' originates from battle medicine as the critical time between injury and skilled intervention which maximises the chance of survival. This is sometimes translated into a travel time limit in discussions of rural medicine.
[2] *Organisation of Acute General Hospital Services*, Joint Consultants Committee (of the Royal Colleges), July 1999.
[3] Source: HHT Mars 4.0 Market Analysis

Table 4: PCT Expenditure 2007/8

Service	County Hospital	Community Hospitals	Community	Primary Care	Mental Health	Learning Disabilities	Total Health	Social Care	OOA	Total
Maternity & Newborn	3,431,769	-	-	-	-	-	3,431,769	-		3,431,769
Children	5,101,995	-	6,918,000	-	-	-	12,019,995	-		12,019,995
Urgent & Emergency Care	22,999,626	-	-	-	-	-	22,999,626	-		22,999,626
Planned Care	26,173,561	-	-	-	-	-	26,173,561	-		26,173,561
Mental Health	317,496	-	-	-	18,538,000	-	18,855,496	6,336,000	7,869,000	33,060,496
Long Term Conditions		7,101,000	-	-	-	1,868,000	8,969,000	-		8,969,000
Staying Healthy										
End of life care	Not shown explicitly. Integrated with other spending streams.									
Long term residential care	No PCT expenditure. LA expenditure is considered separately.									
Other	10,959,566	-	20,240,000	62,328,000		-	93,527,566	-		93,527,566
Total Herefordshire Provision	68,984,013	7,101,000	27,158,000	62,328,000	18,538,000	1,868,000	185,977,013	6,336,000	7,869,000	200,182,013
OOA Acute									56,981,000	56,981,000
Total PCT Expenditure	68,984,013	7,101,000	27,158,000	62,328,000	18,538,000	1,868,000	185,977,013	6,336,000	64,850,000	257,163,013

4.3 Finance

Health The PCT spent £257 million in 2007/8:

- 49% (£126m) on acute care with 26% (£69m) at HHT;
- out of the other £57m acute, £23m represents specialist tertiary services[4], leaving a total of £34m out of area acute;
- secondary acute therefore totals £93m;
- primary care comprises 24% (£62m);
- community care + mental health + learning disabilities comprises 24% (£62m);
- out of area treatment is mainly specialist acute services but it also includes £8m of mental health services.

Social Services The local authority spent £40 million on residential, nursing home and domiciliary care:

- £25m (63%) on residential home placements
- £7m (17%) on nursing home placements
- £8m (20%) on home-based or domiciliary caseloads

The largest single client group, in terms of expenditure, is the elderly with £17m on care home placements for 974 people and £5m on domiciliary care, totalling £22m or 56% of resources. Learning disabilities comprises 27% of spend (£10m) with 167 people placed in care homes.

4.4 Workforce

There are 2,700 FTE staff directly employed in the health sector. Social Services funds independent providers who employ care workers in residential homes and domiciliary services.

Table 5: NHS Workforce 2007/8

Service	County Hospital	Community Hospitals	Community	Primary Care	LD	MH	Total Health	%
Doctor	221		8	122		18	**369**	14%
Nurse	709	131	236	50	25	158	**1,309**	48%
Other Direct Care	243	5	157	91		31	**527**	20%
Other Staff	348	25	73			49	**495**	18%
Total	**1,521**	**160**	**474**	**263**	**25**	**257**	**2,700**	100%
%	56%	6%	18%	10%	1%	10%	100%	

4.5 Services Funded by Social Services

1228 Herefordshire adult residents are being funded to live in residential or nursing homes, representing a reduction of 11% since 2004/5. Community at

[4] Source: PCT Strategic Vision Document, p 32, 'Five Year Overarching Commissioning Strategy – 2008/2013'

home has risen by 21% in volume, leading to a net 14% increase in numbers of people receiving care at home or in accommodation. This contrasts with the 75% increase in the number of assessments and reviews being carried out since 2004/5.

Table 6: Increasing demand for adult social care

Service	04/05	05/06	06/07	08/09	Increase over 4 years
Point of Contact	3915	4566	4871	5725	+46%
Contact leading to assessment	2977	2854	3153	3698	+24%
Assessments and reviews	6545	8241	9405	11425	+75%
Community at home	4510	4908	5037	5467	+21%
Residential + nursing	1378	1381	1326	1228	-11%
Total community at home + residential & nursing	5888	6289	6363	6695	+14%

Individual Budget Agenda. The local government transformation agenda of self directed and individual budgets has established a target of 10% of all adult social care users, including mental health and carers, to have individual budgets during 2008/9. This percentage may increase during 2009-11.

Long Term Conditions and Early Intervention. Social services has invested in more community support to help the growing number of people with long term conditions and complex needs to continue living in their own homes. There has been an active shift in investment towards early intervention in the form of information, advice and support.

Table 7: Early Intervention – information advice and support 2007/8

	Volume	Currency
Signposting scheme - partnership with PCT/Fire Service	3480	Referrals
Village wardens	2215	Contacts
Telecare	550	People assisted
Footcare sessions	1336	People
LIFT exercise scheme	683	Referrals
People supported by joint benefits team (achieving £4.2m additional income)	4000	People

4.6 Hospital-Based Services

All beds in HHT are shown in Table 11. Comparisons with the England average (Table 8) show 235 elective and non-elective adult beds and 267 acute including paediatrics, A&E observation and discharge lounge beds, equating to 1.48 beds per 1000 population, compared to an England average of 2.12 beds per 1000 population, a gap of 31%.

One third of beds in Hereford are located in the community hospitals (see Table 10). If we take these into account, there are 2.18 beds per 1000 population. A similar comparison in England, bringing in geriatric beds, is

2.58 beds per 1000 population, which is 21% above Hereford's provision. This comparison indicates that Hereford is below the national average in its acute + slow stream bed complement.

Table 8: Inpatient Provision

	Hereford Beds	Hereford Beds per 1000 Population	England Beds per 1,000 Population
HHT Adult Elective & Non-Elective	235	1.30	
HHT Paediatrics, A&E observation, discharge lounge	32	0.18	
Acute (ex. maternity)	267	1.48	2.12
Community	126	0.71	0.47 geriatric
Total	393	2.18	2.58

Using England as the comparator, HHT's utilisation against population is lower than average while throughput per bed is higher and, length of stay of medical patients is marginally lower, probably facilitated by availability of beds in community hospitals for step down patients.

Table 9: Utilisation and ALOS Comparison

		ALOS Inpatient FCE	Utilisation = FCE per 1,000 Pop	Throughput = FCE per Bed
ENGLAND	Surgical	3.82	116	
	Medical	4.8	98	
	Total	4.3	214	64
HHT	Surgical	3.82	89	
	Medical	4.3	73	
	Total	4.1	162	81
Difference between HHT and England		-5%	-24%	+27%

Table 10: Beds in Community Hospitals

	Available Bed	Average Daily Occupied Bed	FCE	Average Length of Stay
Ledbury	14	13.0	191	24.9
Ross on Wye	32	29.8	530	20.6
Bromyard	14	12.2	157	28.4
Hillside	22	18.7	326	20.9
Leominster	34	29.2	419	25.4
Kington Court	10	6.5	71	33.5
Total	126	109.42	1,694	23.6

Primary and secondary care clinicians, at their joint clinical forum in August, observed that there is scope to use beds in community hospitals to increase patient throughput and treat a larger number of patients.

Table 11: All Beds in HHT

By Ward	Ward	Speciality	Emergency Beds	Inpatient Beds	Total	Notes
	EAU	Medicine	24		*24*	
	Arrow	Medicine	23		*23*	
	Lugg	Medicine	29		*29*	
	Frome	Medicine	28		*28*	Includes 10 bedded Acute Stroke Unit
	Kenwater	Medicine	22		*22*	
	Leadon	Female surgery & GI medicine	5	18	*23*	
	Monnow	Male surgery & GI medicine	4	18	*22*	
	Wye	Elective orthopaedics		23	*23*	
	Teme	Trauma Orthopaedics		24	*24*	
	Women's Health	Obs. & Gynae		7	*7*	
	CCU			6	*6*	4 Acute, 2 Step-down
	ITU			4	*4*	
		Total	**135**	**100**	**235**	
By Elective/Non-Elective		Elective		48	*48*	
		Non-Elective	135	52	*187*	
		Total	**135**	**100**	***235***	
Other						
	Daycase	Trolleys		20	*20*	
		Chair		6	*6*	
	A&E	Obs	4		*4*	
	Departure Lounge		6	6	*12*	
	Maternity	Inpatient		21	*21*	
	Delivery			5	*5*	
	SCBU	Cots	12		*12*	
	Paediatrics	Inpatient	16		*16*	Capacity 20 (4 not staffed)
		Daycase trolleys	4		*4*	
		Total	**42**	**58**	***100***	
		Grand Total	**177**	**158**	***335***	

4.7 Primary Care

There are 122 general practitioners, equivalent to approximately 1 GP per 1500 population, in line with the national average. The relatively low hospital utilisation suggests that primary care doctors are managing patients that in more urban settings might be treated in hospital.

4.8 Clinical Critical Mass

Healthcare is becoming increasingly specialist at the top of the acuity spectrum, illustrated by sub-specialisation of doctors and movement away from generalist training. Hospitals need to serve large populations (400,000+) to adequately cover the range of specialisms. National and local policy is also aiming to shift treatment out of secondary care and into the community, nearer to patients' homes where possible. Hereford's small population base has led to scrutiny of critical mass.

Medical staffing cover[5] and patient volumes are key components when weighing critical mass. It is an issue that relates to the structure and balance of services in acute hospitals (which provide critical care facilities). We consider individual specialties required to support a general hospital:

- Accident and emergency: a relatively small unit with 46,000 A&E attendances, (less than 40,000 attendances is classed as small by the profession). There are plans to divert primary-level attendances via primary care;

- Critical care services, i.e. ITU and HDU: there are 4 ITU beds at HHT and admissions exceed 200 per annum, viewed professionally as the clinical safety threshold;

- Maternity: there are less than 2000 births (classed as a category A unit at below 2500 births, Safer Childbirth, October 2007). At the time of the review there were 4 consultant obstetricians. The Durrow Report called for an increase in medical staffing. We understand that the PCT has agreed to fund additional staff to maintain a local service;

- Paediatrics: there is a budgeted establishment of 6.9 FTE consultants and 17 doctors overall (including juniors). There has been a rapid rise in consultant numbers, for cover reasons, without apparent corresponding rise in workload (a nation-wide phenomenon). Referral rates are lower than average, suggesting that much care is contained at primary level (new outpatient referrals are 5.5 per 1000 population compared to 10/1000 in England and at 144 per consultant compared to 250 for England).

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[5] The medical profession has leverage in determining clinical quality levels and matches between doctor and patient numbers through the following mechanisms: (a) approval of job plans and adverts for consultant grades, and (b) recognition of training posts.

The implication of this overview is that specialties may require investment to maintain them locally.

4.9 Financial Critical Mass

The PCT spent £257 million in 2007/8, £69 million of which was invested in HHT. Questions of financial critical mass focus on HHT, partly highlighted through the recent bid for Foundation Trust status.

Flows. In principle there is scope to extend care out of secondary into primary care (illustrated by the paediatric summary above). In practice, the NHS financial regime of Payment by Results makes it difficult to redistribute resources from secondary to primary care because average costing (including contribution to fixed costs and overheads) is used rather than marginal costing (reflecting the direct cost of change). It is not clear the extent to which commissioning intentions are bound by these rules or the level of flexibility in resource transfer that is permitted.

Long Term Financial Stability. HHT has a turnover of £104 million and a high PFI mortgage of 12%. PFI depletes the asset base, reducing HHT's ability to raise capital in future years. This, together with the need to achieve continued cost reduction efficiency savings, inhibits HHT's ability to make sustainable plans to replace equipment and upgrade clinical facilities.

Revenue Base. In principle there is scope to repatriate work back to Hereford, given the high out of county expenditure. In practice this would necessitate (a) investment in additional clinical capacity and (b) change of referral patterns. Further work is needed to explore this.

4.10 Conclusion

Hereford's population base is small, but nevertheless needs to be supported by an acute hospital to provide proximity within an hour's travel radius across the county. There is a case for change on the grounds of financial structure and the need to access capital in the future.

5. Non-financial Option Appraisal

5.1 Development of success criteria

Building on a July workshop with the Stakeholder Advisory Group, HSMC developed a list of success criteria based on the key principles underpinning the review (see section 1 above) and on options appraisal work undertaken in other health and social care communities. These criteria were then agreed at a Steering Group meeting in August 2008 and used to structure discussion at a subsequent half-day options appraisal workshop (10th September 2008). The criteria are set out in Table 12 below.

5.2 Engaging with stakeholders to explore future options

HSMC held a series of interviews with provider stakeholders from the PCT, HHT, Ambulance Trust, Herefordshire Council and voluntary sector organisations. These provided an opportunity to share more widely the aims and progress of the wider review and to obtain views as to the future provision and options for organisational configuration in Herefordshire.

Overall, people were of the view that the quality of service delivery was more important than the configuration of organisations and that the benefits of going through a major organisational restructure needed to be very clear. However, most also commented that the needs of the population were changing and therefore change was necessary if '*local services were going to keep* up'.

The clinicians interviewed were the least receptive to organisational reconfiguration stating that it would detract staff from doing the *'real work'* and not solve the underlying issues of professional collaboration and care coordination. Most interviewees commented that services needed to work more closely together than happens currently to ensure care is co-ordinated but that this could (and should) be achieved through the joint development of care pathways. Work in progress on care pathways as a result of the review was seen to be extremely positive with comments such as '*this is the first time all organisations have talked together about what needs to be done';* it is paramount that this work is sustained and appropriately resourced, as previously recommended.

Retaining local hospital services was seen of paramount importance although as one cabinet member remarked '*people are happy to travel out of the county for specialist services; they know we can't have everything'.* All those interviewed agreed that Herefordshire needed its own A&E and maternity service given the local geography. The provision of services was seen as more important than the organisation that delivered them although an *'outside organisation'* such as another Trust was not felt to be locally acceptable.

Some clinicians and voluntary organisations had reservations about creating a large monopoly provider of acute and community services suggesting it may prevent other providers from having an opportunity to enter the market and reduce the tension in the system necessary for innovation and patient

responsiveness. There was also concern that if commissioning was weak resources would shift towards acute care and '*potentially strip community services'.* One GP felt strongly that if this was the preferred option then GP presence as a provider on the board should be explored within future governance arrangements.

However, some reflected views of others involved in the review that *'something needed to be done to help everyone work together'* and that a new organisation may be what is required. What was expressed very strongly however was that this should not be a 'take over by any organisation but a new one created.

Some working in the voluntary sector commented that closer working relationships were needed between themselves and the statutory organisations. They were less clear about how an organisational change could improve services but felt their knowledge of local communities was not exploited to its full potential. They were often asked by service users to explain how services worked or why certain decisions had been made but were often unclear themselves. In this respect, they felt they could support the PCT and Council in working with and engaging users in service developments.

5.3 Children's and Mental Health Services

Due to the complexity and nature of these services, the future organisational model for these services are being considered outside of this review following the agreement of a preferred option for the other services. The integration of children's services to meet national standards is a high priority for the County and involves stakeholders outside the scope of this review. The population size of Herefordshire suggests that the ongoing provision of a mental health service by the PCT may not be clinically or financially robust and options for the provision of this service by a Mental Health Trust are being considered. However, the need to integrate these services with other services in the County is seen as crucial to the overall strategic care model and the impact of any organisational configuration on the delivery of these services will need to be taken into account.

5.4 The "long list" of options

Drawing on the input of the eight Darzi-based workstreams, and on interviews with key stakeholders as above, HSMC developed the list of options for future organisational configurations set out in Box 1 below, excluding children and mental health services. From the beginning, it was noted and agreed that these options would have significant implications for mental health and for children's services – and it was decided that these were so important that they needed to be addressed separately (rather than running the risk of failing to do them justice as part of more general discussions). Where general practice is included in the options this refers to them having a provider representation within the governance structure of an integrated organisation,

Although ‘do nothing’ was retained as a potential option, as is customary in option appraisals, this had already effectively been ruled out by the Steering Group based on a collective view that remaining with the current organisational configuration was not sustainable in the long-term. These options were agreed by the Steering Group at their August 2008 meeting and were used to structure discussion at the September 2008 option appraisal workshop.

It was also decided by the Steering Group that the appraisal exercise would be used to exclude some clearly unworkable options, and to shortlist those with potential to be considered in more detail once the details of the proposed care pathways have been fully worked up, and their implications assessed. At that point it will become possible to determine which provider option would best underpin the strategic model of care, on the principle that “form should follow function”.

5.5 The option appraisal process

At the September 2008 option appraisal workshop, participants were presented with the success criteria and options to date. This event was attended by over 30 local stakeholders, including elected members, non-executive directors, managers and practitioners, and including representatives from acute care, primary care, community health services, social care, children’s services, mental health and the voluntary sector. Working in five mixed groups, participants were asked to rank each option for future service provision against the success criteria in Table 12, ranking each option out of 3 for each criterion (with 1 = low chance of meeting the criterion, 2 = medium chance and 3 = high chance). Results were then fed back in plenary and summarised quantitatively. Groups were also asked to feed back the rationale for their preferred option, any options which they had definitely ruled out, and any areas where it had been difficult to achieve consensus. Throughout this workshop, the aim as explained above was to narrow down the initial long list of options, and also to explore key themes and to identify any emerging consensus about the future direction of travel.

Table 12: Success criteria

Shortlist criteria	*Description*	*Scoring High/Med/Low*
Promotes quality	• maintains or improves health and wellbeing outcomes • provides appropriate range of care pathways • delivers pathways that are evidence based • delivers safe services • provides timely and appropriate services • minimises clinical risk • flexible and well-placed to innovate • reduces variability of quality and safety	
Sustainable	• retains critical services in Herefordshire • provides environments which support the recruitment/retention of staff • supports clinical staffing requirements • ability to meet current and future demands in activity • ability to respond to future local and national service changes • works beyond the short term	
Improves health inequalities	• promotes health gain • supports delivery of Investing for Health outcomes • supports shift to preventative care • improves access	
Acceptable to stakeholders	• acceptable to clinicians, service users, carers and public • reflects local ethics/values of health and social care • inspires public confidence • promotes the development of social capital, responsive to and enriching local communities	
Makes best use of local resource (non-financial)	• supports integration of service delivery • provides flexibility to build on existing joint working • makes best use of existing estate • supports clinical and financial alignment	
Coherent with national and local policy	• supports achievement of key targets • offers user choice • shifts care closer to home • supports Putting People First • supports management of long term conditions	

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Box 1: Options for future service provision in Herefordshire

1. Do nothing (i.e. continue to implement new service models, but retain existing organisational structures)

2. Maintain local hospital services through work with a nearby Foundation Trust (FT):

   2a) Integrate organisationally with nearby FT

   2b) Develop clinical networks in key specialties to ensure service viability.

3. Build the hospital bed base through acquisition of community hospitals

4. Create a new integrated hospital and community health organisation

5. Create a new integrated hospital, community health and adult social care organisation

6. Create a new integrated hospital, community health, adult social care and general practice organisation

7. Create a new integrated hospital, community health and general practice organisation

8. Integrate community health and adult social care (together with pursuing option 2a/2b for hospital care)

9. Integrate general practice and community health care (together with pursuing option 2a/2b for hospital care)

10. Vertical integration of hospital and community hospital services and horizontal integration of community health and adult social care

11. Integrate general practice, community health and adult social care (together with pursuing option 2a/2b for hospital care)

5.6 Outcome of appraisal

When all the scores from each group were collated, there was significant consensus in the group's preferred options and for options that were not generally supported. While more detail is provided in Appendix 3, the top three preferences expressed by workshop participants (in order of preference) were for:

4. A new integrated hospital, community health and adult social care organisation (Option 5).

5. A new integrated hospital, community health, adult social care and general practice organisation (Option 6).

6. Integrating general practice, community health care and social care, whilst also pursuing option 2a/2b for hospital care (Option 11).

In addition to these top three, most groups emphasised that the options presented were not mutually exclusive, and that Option 2b should in any case be pursued alongside other options. Given gaps in current data, it was not yet clear to groups whether this option would be sufficient to safeguard local hospital services in the long-term, or whether it would need to be supplemented by other approaches – however, groups were clear that not pursuing clinical networks was not an option.

Of the preferred three options, there was strong consensus from all groups about the desirability of Option 5, but more mixed views across different groups about Option 6.

In contrast, the least preferred options (lowest score first) were:

1. Do nothing (Option 1), which was explicitly ruled out by all present.

2. Integrate general practice and community health care (together with pursuing option 2a/2b for hospital care) (Option 9).

3. Integrating organisationally with nearby FT (Option 2a).

4. Creating a new integrated hospital, community health and general practice organisation (Option 7).

5. Creating a new integrated hospital and community health organisation (Option 4).

6. Building the bed base through acquisition of community hospitals (Option 3).

In making these distinctions, groups identified a number of key themes that had helped to guide their thinking:

- There was strong consensus that doing nothing was not a credible option, and clear recognition that existing organisational structures were not necessarily the best way of delivering better outcomes for patients and service users.

- Participants were clear that any future option had to involve social care (and therefore tended to reject options that focused solely on health care).

- Participants stressed the need for a whole systems approach (and therefore tended to mark down or reject any option that seemed to be

focusing on one part of the system in isolation or failing to tackle perceived inter-organisational barriers in the current system).

- Debates about organisational structures should not prevent ongoing and detailed work with regards to new service models (which should be agreed and implemented irrespective of future decisions about current organisations).

In addition to this, groups also reiterated a point made above (section 5.2) that mental health and children's services are key elements of the work of many local health and social care organisations, and that these should not be neglected. Similarly, there was a strong statement of the need to include greater and more meaningful involvement from the third sector in future organisational discussions.

The Steering Group at its meeting on the 17th September agreed that the highest ranking options listed above (5, 6 and 11) should go forward to the shortlist and additionally options 8 and 10. Meanwhile Option 2b ("develop clinical networks in key specialties to ensure service viability") was agreed as a "given" that should take place whatever other configuration change took place.

5.7 Additional issues

In addition to discussion of preferred organisational models, groups raised a series of broader issues about any future process of change, including:

- While some options have the *potential* to bring more benefits than the current structure, these are not guaranteed – how changes are implemented and how staff are supported/engaged will be crucial.

- Whatever approach is adopted, strong commissioning will be crucial to specify the outcomes that local services should be seeking to deliver.

- If a decision is taken to develop a more integrated organisational structure, then it will be important to develop some sort of locality approach which enables appropriate decisions to be devolved to local level (i.e. to prevent the dangers of creating a structure that is too large, unwieldy and impersonal).

- A key dilemma is how best to balance prevention/well-being with services focused on treating ill health. Whether or not this balance is best struck by integrating both functions into a single organisation or by preserving a separate focus on each through separate structures remains a key issue for exploration. This also links to the point above about the importance of strong commissioning.

- Much of the workshop was focused on trying to find ways of continuing to provide services locally that are both clinically and financially viable (in the

short- and the long-term). While these are technically separate issues, they are also very closely linked.

- In considering the potential for closer relationships with external organisations (for example, a nearby FT as highlighted in options 2a/2b), it will be important to consider the potential motives and likely actions of such an external partner, both now and in the future.

5.8 Organisational integration - lessons from the partnership literature

Integrated organisations

The creation of a new integrated organisation emerging from HHT and PCT provider services would set a precedent for provision but not dissimilar to the current Isle of Wight model that has integrated hospital and community services within the existing PCT.

The organisational entity for this would need to be carefully explored within current options available and is not without its complexity. In theory, the organisation could be established as a new hospital or community FT, but the route for getting to this point could be extremely complex involving disbanding HHT, creating a new NHS Trust and moreover the legislation for community FTs is not yet in place. At the time of writing the report the legal option for the new organisation to be some form of social enterprise is not clear. Whilst not appearing acceptable to some in Herefordshire, there is of course the option for an integrated organisation to be created from either HHT or the PCT and to include adult social care. A number of implications would need to be considered with regard to developing a new integrated organisation:

- Clarity as to what specific outcomes are sought by the change
- The desired governance arrangements (e.g. GP representation) and flexibility to achieve these within the available organisational options
- Range of services to be included
- Impact on wider stakeholders and levels of influence
- Impact on the workforce and existing team configurations
- Commissioning mechanisms and levers to ensure quality and cost effectiveness prevails
- Transitional arrangements from current organisations for staff
- Overall cost of transition

What the evidence tells us

Despite significant local enthusiasm for integration as a potential tool to tackle the difficulties of providing rural health and social care, there are a series of lessons from the broader partnership literature that may be helpful when considering the next steps. In particular, the available evidence (from both public and private sectors) cautions against an over-reliance on structural solutions – while structural change can sometimes be part of the way forward,

it should be embarked upon with care and sensitivity. As a very brief overview, there are four key issues:

1. A helpful contribution is made by Walter Leutz (1999), whose review of the evidence in the US and the UK has led to the development of 'five laws of integration' (see Box 2). Amongst other things, these warn against too much integration all at once and against expecting results too quickly.

2. This is supported by broader research into the impact of mergers and acquisitions (see, for example, Field and Peck, 2003; Fulop *et al*., 2002, 2005; Peck and Freeman, 2005; Peck *et al*., 2002; Social Services Inspectorate/Audit Commission, 2004), which suggests that structural change alone rarely achieves stated objectives, that it can often be a distraction for staff and managers, that it can give a false impression of change, that it often does not save money, that it can reduce morale and productivity, that it can stall positive service development, and that (in the NHS at least) it often takes place for reasons other than those stated in formal consultations (for example, responding to local/national politics and/or removing management teams that are perceived to be failing).

3. In addition to structures, it is important to pay significant and ongoing attention to issues of organisational and professional culture (see, for example, Dickinson *et al*., 2006; Peck and Crawford, 2004).

4. Partnership working and integration can often become an end in themselves, rather than a means to an end (of better services and better outcomes for people who use them - see Glasby and Dickinson, 2008 for a more general overview).

This is not necessarily to rule out structural change, but it does suggest that:

- Local partners need to be clear about the outcomes they are seeking to achieve.

- They need to be clear about why a partnership (and why this form of partnership) is the best way to achieve these outcomes.

- They need to be prepared for the significant and long-term negatives impacts which can arise from structural change.

- They need to be clear that the outcomes at stake are worth this upheaval.

Where health and social care communities can respond positively to these challenges, then structural change may be an appropriate part of the way forward (alongside additional work on organisational and service development). However, many of these issues can be summarised in a simple challenge that all would-be partners would be well advised to address if their inter-agency relationships are to remain as a means to the end of better services and better outcomes: *if integration is the answer, what is the question?*

Box 2: Five 'laws of integration' (Leutz, 1999)

1. You can integrate some of the services for all of the people, or all of the services for some of the people, but you can't integrate all the services for all the people.
2. Integration costs before it pays.
3. Your integration is my fragmentation.
4. You can't integrate a square peg and a round hole.
5. The one who integrates calls the tune.

6. Conclusions and Recommendations

When this review was first commissioned and the process to deliver it discussed with the Steering Group, the scale of the task ahead in terms of developing a well articulated and a reasonably quantified strategic model of care with associated care pathways may not have been fully appreciated by many. While it was suggested that there was already a degree of clarity of direction around each of the Darzi workstreams, in practice while some strong pockets of discreet activity were underway, much had still to be initiated.

The first challenge for the groups was to assess the applicability of the West Midlands Darzi models to Herefordshire, and to commence the task not only of formulating a local vision but of providing the detail - in terms of resource requirements and activity shifts - that would enable the new model to be costed. The SHA-driven timescale to complete the review in six months was extremely tight which brought its own challenges for involving health and social care professionals. It required work on the care models to be given the highest priority by all organisations in terms of time and senior leadership.

The review has not progressed to an agreed preferred organisational option within the given timescale. This is mainly due to it coinciding with work required to meet the World Class Commissioning agenda creating competing priorities for senior management time, the appointment of two key senior staff during the review timescale and recognition that there was catching up to do in establishing the required strategic planning structures and processes that can deliver work of this nature effectively.

Engagement

Excellent engagement of some key stakeholders, including clinicians, has been achieved through the working groups. Lack of staff capacity due to a prioritisation of performance issues within the Local Authority meant their involvement has been very limited in the working groups and this leaves a significant gap in the models developed to date. However, the review has

demonstrated a real desire amongst the clinical and social care community to work together to achieve better outcomes for patients through improved co-ordination of care, greater integration and service efficiency. It is paramount that this is fostered and developed within a clear joint agency commissioning approach in which all players understand their roles.

The review of membership, and commitment to provide further support to the groups, which was agreed by the Steering Group as HSMC's input was concluding, is to be welcomed. Furthermore, more comprehensive engagement of the third sector and user and carer representatives will help ensure that models are appropriate and delivering the type of care that is wanted by potential consumers. A message from many stakeholders was "*we've been here before, and then nothing has been taken forward":* this time a *carpe diem* approach is strongly recommended with this work being translated into commissioning plans.

Case for organisational change

The strategic care planning process has not been completed and therefore it would be premature at this stage to conclude a case for organisational change. From work achieved to date, there is nothing to suggest that the desired service outcomes expressed by the working groups could not be achieved through the development of integrated care pathways and clinically integrated systems. As stated above, we know that structural solutions rarely deliver the outcomes intended and the cost and other effects of major structural change need to be weighed very carefully against the expected long term benefit to the Herefordshire population. There is no appetite within the clinical community for major organisational change without a clear rationale and so to gain their co-operation and involvement the case for change needs to be very clear.

However, it can be argued that Herefordshire has other drivers which suggest the development of a new integrated organisation is worth exploring in more depth once care models are agreed and the impact of those on each organisation is understood:

- the local geography which requires sustaining essential hospital services
- the long term financial viability of a separate hospital Trust for the size of Herefordshire
- the long term viability of the PCT provider services within the current policy context to separate commissioning and provision
- the policy requirement for all NHS Trusts to become Foundation Trusts and the challenges this creates for a small DGH

- the historical culture within Herefordshire, expressed by many, of organisations operating as silos in service development and planning

- the outcome of the initial option appraisal to pursue an integrated organisational model

These factors should be considered alongside the economic and activity modelling when the pathways are fully established. Whilst each by themselves may not constitute a robust case for change, viewed as a whole picture the case for change may be stronger. It is important to remember however the lessons learnt from other major reconfigurations. There may be a temptation to shortcut the process of developing agreed care pathways, clear commissioning plans and ensuring clinical ownership of change across the whole clinical community and rely on a structural solution. However without achieving this clarity and consensus and having a robust rationale for change it will be much more challenging to deliver the desired improvements in health and social care to the population.

Recommendations

Our work supporting the review leads us to the following recommendations for ensuring that an appropriate way forward is found that will best meet the health and social care needs of Herefordshire people:

- To further strengthen and practically support the working groups to produce the care models at a level of detail that can ensure understanding of the whole system impacts and be costed to inform a case for change

- To appoint a project manager with the appropriate skill set and authority to lead the ongoing work of the working groups

- To establish a clear approach to commissioning that takes account of both the working groups and the newly-established clinical forum, and sustains and builds on the wider stakeholder engagement achieved through this project. A well-defined strategic planning structure informing commissioning will underpin not only the conclusions of the provider review but also the joint working/strategy development that needs to gather momentum

- To ensure that appropriate attention is given to the complex areas of mental health and children's services (not least child and adolescent mental health which is at the intersection of these two fields but can fall between them). There are existing integration issues to pursue in both these areas and the relationship of these to the aspiration for greater integration for other services need to be fully understood. A high level of commissioning leadership and support is likely to be needed to balance these different agendas.

- To reflect as a Steering Group upon the potential for integration to support the strategic model, seeking clarity as to the areas of care where integration has most to offer to Herefordshire people, and taking into account the pitfalls highlighted in the literature as set out above.

- To ensure greater involvement of wider stakeholders including the voluntary sector within the service planning process.

- Once the implications of the strategic model of care are clear the short-listed options described above should be developed in greater detail so that they can be more comprehensively assessed and subjected to the types of test set out in section 5.7 above alongside an objective financial assessment.

- To explore the potential of an integrated urgent care model for Herefordshire as a Department of Health pilot site

- If a case for change for organisational reconfiguration is agreed then work needs to be undertaken to identify the most appropriate organisational and governance model.

7. References

Dickinson, H., Peck, E. and Smith, J. (2006) *Leadership in organisational transition – what can we learn from research evidence? Summary report*, Birmingham: Health Services Management Centre.

Field, J. and Peck, E. (2003) 'Mergers and acquisitions in the private sector: what are the lessons for health and social care?', *Social Policy and Administration*, vol 37, no 7, pp 742-755.

Fulop, N., Protopsaltis, G., Hutchings, A., King, A., Allen, P., Normand, C. and Walters, R. (2002) 'Process and impact of mergers of NHS trust: multicentre case study and management cost analysis', *British Medical Journal*, vol 325, pp 246-252.

Fulop, N., Protopsaltis, G., King, A., Allen, P., Hutchings, A. and Normand, C. (2005) 'Changing organisations: a study of the context and processes of mergers of health care providers in England', *Social Science and Medicine*, vol 60, no 1, pp 119-130.

Glasby, J. and Dickinson, H. (2008) *Partnership working in health and social care*, Bristol: Policy Press.

Hudson B (2005) The Durham Adult Community Care Enhancement Strategy for Sedgefield: Final report. HMSO

Hudson B (2006) Integrated Team Working: You can get it if you really want it Part 1. Journal of Integrated Care, 14:1 p,14 - 23

Leutz, W. (1999) 'Five laws for integrating medical and social services: lessons from the United States and the United Kingdom', *Milbank Memorial Fund Quarterly*, vol 77, pp 77-110.

Peck, E. and Crawford, A. (2004) *'Culture' in partnerships - what do we mean by it and what can we do about it?*, Leeds: Integrated Care Network.

Peck, E., Gulliver, P. and Towell, D. (2002) *Modernising partnerships: Evaluation of Somerset's innovations in the commissioning and organisation of mental health services – final report*, London: Institute for Applied Health and Social Policy, King's College London.

Peck, E. and Freeman, T. (2005) *Reconfiguring PCTs: Influences and options* (briefing paper prepared for the NHS Alliance), Birmingham: Health Services Management Centre.

Social Services Inspectorate/Audit Commission (2004) *Old virtues, new virtues: An overview of the changes in social care services over the seven years of Joint reviews in England, 1996-2003*, London: SSI/Audit Commission.

APPENDIX 1

STEERING GROUP MEMBERSHIP

Akeem Ali	Director of Public Health	PCT
Andrew Watts	GP & PbC Chair	
Budd Alison	Medical Director	HHT
Chris Bull	Chief Executive	PCT & Council
Eleanor Brazil	Interim Director Adult Social Care	Council
Helen Parker	Co-Director,	HSMC, University of Birmingham
Ian Tait	PaCE Chair	HHT
Ian Williams	Director, Integrated Commissioning	PCT & Council (from August)
Jane Rogers	Non-Executive Director	PCT
Joanna Newton	Chairman	PCT
Kathy O'Mahony*	Head of Community Operations	Council
Margaret McArthur	Senior Associate	HSMC, University of Birmingham
Mark Curtis	Chairman	HHT
Paul Edwards	Director of Commissioning & Strategy	PCT
Rob Ewing	Business Change Manager	Council
Sharon Menghini	Director of Children's Services	Council
Sue Doheny	Managing Director Provider Services	PCT
Martin Woodford	Chief Executive	HHT

* replacing Margaret Dennison from September

APPENDIX 2

Herefordshire Provider review

Short report from a HHT and General Practice workshop 21st August 2008

1. Introduction

Herefordshire Primary Care Trust (PCT), Hereford Hospitals NHS Trust (HHT) and Herefordshire Council commissioned the Health Services Management Centre (HSMC) to work with them in a strategic review that will *'ensure that provider services are fit for purpose and organised in sustainable configurations which are able to both drive service improvement and deliver real efficiency'*

A key element of this work has been service modelling by local working groups to develop integrated care pathways based on the regional Darzi outputs. The review recognises the importance of ensuring that any new agreed models of care uses medical expertise efficiently and in a manner that provides best care for patients. In recognition there was no formal mechanism for senior clinical engagement across primary and secondary care in the review process a workshop for Consultants and GPs was held to identify areas of consensus and provide opportunity for their contribution and influence in further development of the pathways.

It also provided opportunity for Consultants and GPs to have time out from clinical caseloads to discuss current working arrangements and agree new ways of working between them where appropriate.

The workshop also had a presentation from Dr Ali in the future demographic changes within the county and the potential impact of these on future service delivery.

1.1 Workshop attendees

Helen Parker,	HSMC and facilitator
Tessa Crilly,	Crystal Blue Consulting and member of review team
Dr Akeem Ali,	Herefordshire Primary Care Trust

HHT	**General Practice**
Michael Hall	Marian Davis
David Mowbray	Martin Crook
Simon Meyrick	Kevin Ilsley
Alison Budd	Crispin Fisher
Peter Wilson	Nigel Frazer
Victoria Alner	Andrew Watts
Rupert Ransford	Andrew Black
Clare Cheek	

2. Discussion Summary

The workshop covered a number of areas significant for the review. (Others areas of partnership working were discussed but not included in this report.)

2.1. Community Hospitals

Community Hospitals, as well as HCH, are seen as potential areas for improvement in overall efficiency as a resource within the whole health and social care system and in the quality of patient of care. It was acknowledged that the delayed discharges for some patients were largely a result of social care resource constraints (staff, funding and available care home beds) that prevented discharge back home or to residential care[6]. However, this is resulting in blocks in other parts of the system, most importantly in HHT's ability to transfer people back to a community setting in a timely manner. Discharges may also be delayed if a patient is self-funding or has PCT funding agreed due to indecision by the patients or families to identify a suitable care home place. The impact of this is a significant inefficient use of HCH beds that prevents, for example, increasing productivity in elective care.

It was agreed that the hospitals needed to be redefined in their remit to support integrated care pathways and have clear criteria for in-patient activity. There was a consensus that the key roles of the hospitals should be as follows:

- 24/7 short term step up in-patient care when acute hospital care is unnecessary
- 24/7 step down rehabilitation to ensure timely transfer from HHT

Consultants felt it important that access to community hospital beds should be on 7 days per week. There was consensus that *integrated community health and social care teams* (MDTs) were crucial for ensuring patients requiring complex care arrangements were ideally not admitted unless medically required but if admitted were transferred through the HCH and community hospitals appropriately. It is suggested that an important role of these teams would be to retain case management responsibility and track patients through HHT, with responsibility for discharge planning in liaison with ward staff. Care for these patients should be supported by outcome-based care plans to facilitate transfer back home, or to longer term care, when appropriate.

There was a general consensus that these teams should be developed on a locality basis with additional resource for Hereford City in recognition that it has no community beds.

- Outpatients where there is a critical mass.

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[6] A delayed discharge was defined as a patient who had been an inpatient at a community hospital for 21 days or more, who had no on-going re-ablement goals as identified by the multidisciplinary team or medical conditions requiring that admission

It was agreed that there is still much work to do as part of the ongoing strategic planning process in mapping current and future activity to inform exactly what outpatient activity will be provided in community hospitals. It was agreed that this work needed to be undertaken as part of the practice-based commissioning development and within the framework of an established strategic planning structure (see below).

- Day case treatment.

- Urgent Care.

  Again there was a consensus that this still needed much further work before any decisions could be made about the care provided in each community hospital and therefore the workforce or resources required.

- Maternity as per the working group report.

- Palliative Care as per the End of Life working group report

- Diagnostics (X-ray and Ultrasound)

  There was consensus (and concern) that very little work had been done so far to identify the diagnostic support required for the new pathways. Key people had not been involved and highlighted the need for a more robust approach to strategic planning in the County. It was agreed that the diagnostic support to community activity is crucial in ensuring clinical viability and until this work had been done no care model can be deemed agreed or signed off.

- Specialised Stroke rehabilitation

  It was agreed that stroke care currently provided in community hospitals needed improving and that this may be done by creating a specialist unit in one hospital.

2.2 *Urgent Care/A&E*

A long discussion was given to the future of A&E services in Herefordshire and the future management of primary care activity that is currently provided there. There was a very strong consensus that it was crucial to ensure that A&E services remain on the hospital site even if this meant paying above the national tariff. This is due to the local geography and needs of the population but also on the impact that losing the Department would have on the viability of other services within the hospital.

There was a consensus that an integrated model of care between primary, secondary and social care was potentially the ideal model for Herefordshire in line with the existing ‘emergency room project’.

This requires high quality front door triage, directing patients to appropriate primary or secondary care facilities. A&E should be a dedicated trauma and emergencies unit. Creation of a Clinical Decisions Unit with rapid access to diagnostics would reduce the need for unnecessary admissions. Access to an integrated primary health & social care team would be essential as one option for the triage team.

It was agreed that the team would be able to 'fast track' patients to clinics as part of primary and secondary care pathways from the Department.

A high quality Out of Hours Service was agreed to be crucial to the overall urgent care and A&E service. The links to this service need to be clear within agreed pathways to ensure it does not lead to unnecessary admissions or A&E attendances. Clinicians were agreed that future contracting for this service should include quality of care indicators and not contracted on cost alone. It was agreed that the ShropDoc model should be explored as a potential model for Herefordshire.

2.3 Repatriation of care

Clinicians were surprised at how much care was provided out of county and that this totalled approximately £50 million or 21% of the total budget.

It was agreed that this was a cause for concern and that work needed to be done to map how much activity could safely be repatriated into the county.

2.4 Financial Incentives

It was acknowledged that the financial incentives operating in the current system of PbR and PBC could hinder clinical improvements, e.g. where transfer from hospital to primary care is costed at average tariff rates of, say £100 per outpatient attendance, there is a disincentive to restructure care pathways, since £100 exceeds the direct (marginal) cost of treatment. There was a willingness to maintain clinical dialogue to explore ways of overcoming some of these obstacles.

Conclusion

The workshop was extremely productive and has resulted in a number of recommendations for the review and for ongoing strategic planning. These are summarised as:

1. The integration of health and social care needs to be more strongly developed to support the new care pathways. In particular this is crucial to the effective management of patients in community hospitals and in A&E.

   The development of locality based multi-disciplinary teams should be pursued.

2. Based on work so far, it would seem that most improvements required in clinical services will be solved by clinical redesign of pathways and social care contribution rather than a reconfiguration of the organisational structures.

3. There needs to a review of diagnostic services across the county informed by the outputs form the working groups. This is crucial to informing any potential reconfiguration of providers

4. Sustaining A&E services in Hereford is crucial and an integrated model of care should be developed to support this

5. A robust strategic planning structure needs to be established to ensure stronger clinical engagement and that the most appropriate people are involved in the individual working groups.

   More work is required in a number of areas before there is sufficient ownership and agreement of future care pathways and therefore the ability to undertake robust financial modelling.

6. There needs to be opportunity for an ongoing forum for Consultants and GPs as part of that structure

Helen Parker
On behalf of the Consultants and GPs in attendance
September 2008.

Appendix 3: Scores for each potential provider configuration option against the criteria groups

TOTAL	1	2a	2b	3	4	5	6	7	8	9	10	11	Total
Promotes quality	7	9	11	8	8	13	10	7	8	7	9	11	108
Sustainable	5	8	12	10	10	14	11	9	8	6	9	9	111
Improves health inequalities	6	6	8	7	8	12	12	7	11	9	11	11	108
Acceptable to stakeholders	9	6	10	8	7	14	9	7	9	6	8	8	101
Makes best use of local resource (non-financial)	6	6	9	9	9	14	12	8	10	7	10	11	111
Coherent with national and local policy	6	8	10	9	7	10	8	7	12	7	11	11	106
Total	39	43	60	51	49	77	62	45	58	42	58	61	645
Overall Rank	1	3	9	6	5	12	11	4	7	2	7	10	

Individual table rankings per option

Rank Group 1	2	1	5	3	8	12	8	5	8	3	8	5
Rank Group 2	1	1	9	1	1	12	1	1	1	1	10	11
Rank Group 3	1	5	8	6	1	9	12	1	9	1	7	11
Rank Group 4	1	7	6	11	7	12	3	3	7	1	7	3
Rank Group 5	1	4	10	8	4	10	10	3	9	1	4	4