

Greater Manchester Joint Commissioning Board

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Date: 18 December 2018

Subject: Standardising Acute and Specialised Care Programme – Neuro-Rehabilitation Services

Report of: Diane Whittingham, Associate Lead, Theme 3 - Standardising Acute and Specialised Care Programme, GMHSC Partnership

PURPOSE OF REPORT:

(This report is categorised as relating to “Level B” business as set out in the JCB Terms of Reference – Section 10)

This report builds on previous updates on a new recommended Model of Care for Neuro-Rehabilitation Services provided to the Greater Manchester Joint Commissioning Board (JCB).

It provides a summary of the outcomes of the presentation of the Model of Care to the Greater Manchester Joint Health Scrutiny Committee (JHSC) on 14th November 2018 and their resolutions in support of the model.

This report also provides a summary of the impact of travel on equality issues in regards to meeting the duties relating to Section 149 of the Public Sector Equality Duty outlined within the 2010 Equality Act.

This report invites the JCB to begin consideration of the next steps for the Neuro-rehabilitation model of care including decisions on the lead provider, lead commissioner and the timescale for development of a business case.

RECOMMENDATIONS:

1. The Joint Commissioning Board is asked to note the resolutions of the Greater Manchester Joint Health Scrutiny Committee.
2. The Joint Commissioning Board is asked to consider that the proposed changes to the neuro-rehab service design and delivery have met the statutory requirements of the Equality Act 2010 and in particular section 149 – ‘Public Sector Equality Duty’.

3. The Joint Commissioning Board is asked to accept that the recommendations with regard to the impact of travel of on equality issues will be considered as part of establishing and delivering a new service delivery model.
4. The JCB is asked to consider the proposals for the next steps for the Neuro-rehabilitation Model of Care and confirms its decision on the initiation of these steps.

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1.0 INTRODUCTION AND BACKGROUND

- 1.1 People in Greater Manchester (GM) are admitted to hospital when their needs could be better met in the community. This continues to increase the pressure on our hospitals and means that our highly trained staff are not freed up to do what they do best: provide more specialist care to those who are most ill. Our population is changing so services need to adapt - more of the population has developed multiple long-term conditions, the focus has shifted from curing illnesses to helping individuals to live with chronic ill health closer to home.
- 1.2 There are variations in provision and standards of care across the region. Patients with the same severity of the same condition don't always have the same outcome and sometimes are more likely to stay in hospital for an unduly long time depending on which part of the hospital system in GM they first attend.
- 1.3 Our services are under pressure to meet the rising needs every year, there is immense strain on resources, significant variation in our estate (i.e. our buildings and where we deliver services) in relation to location, age and quality of facilities, we face significant financial and workforce pressures. Change has to happen if we are to maintain the safety and quality of care in the future.
- 1.4 The 'Standardising Acute and Specialised Care Programme' is the third of five interlinking and co-dependent themes identified in the Greater Manchester Health and Social Care Partnership strategic plan '*Taking Charge*'.
- 1.5 The transformation priorities for the Programme were developed with clinicians, providers and commissioners over several months culminating in a proposal which was endorsed by the Association Governing Group, Provider Federation Board, and the Strategic Partnership Board Executive on the 19th September 2016. The following services are in scope of this Programme:
 -) Cardiology
 -) Respiratory
 -) Musculoskeletal/Orthopaedics
 -) Benign Urology
 -) Paediatric Surgery
 -) Breast Services
 -) Vascular
 -) Neuro-Rehabilitation
- 1.6 The decision making body for the Programme is the Greater Manchester Joint Commissioning Board, (JCB). This Board was established as part of the Greater Manchester Health and Social Care Devolution programme and has been meeting since 2015. More recently, work has been ongoing to give the Board formal Joint Committee status, ensuring it is properly constituted to take decisions relating to the Programme.

- 1.7 Membership of the JCB is drawn from across the 10 GM localities, with a clinician, politician and officer from each locality. In addition, GMCA and the GM Health and Social Care Partnership, (in their role as the local representatives of NHS England), are also members.

2.0 NEW PROPOSED MODEL OF CARE FOR NEURO-REHABILITATION SERVICES

2.1 On 16th October 2018, the JCB confirmed their support of the new proposed clinical Model of Care for Neuro-Rehabilitation service and the Model of Care's recommendations, notably:

-) Supporting patients to receive high quality Neuro-Rehabilitation care in the right setting
-) Establishment of a single provider arrangement for bed-based rehabilitation services
-) Single commissioning arrangement for bed-based rehabilitation services

A short summary of the Model of Care is provided in Appendix 1 to this report.

The GM Joint Commissioning Board confirmed that the scale of change in regard to the number of patients affected and the level of engagement with key stakeholders (patients, carers, public, Healthwatch, staff, specialist clinicians etc.) had been proportionate.

2.2 The evidence pack provided to support recommendations for this Model of Care was presented to the Greater Manchester Joint Health Scrutiny Committee (JHSC) on 14th November 2018.

The JHSC was asked to

-) Endorse the Joint Commissioning Board's recommendation that this is not a substantial change to the service in view of the low numbers of patients and the level of public and patient engagement has been proportionate.
-) Confirm that they are satisfied that the proposals in the new models of care will best meet the needs of patients in GM and significantly improve the outcomes for patients.
-) Confirm the process to design the new Model of Care proposals has been jointly designed/developed with both patients and families, and with clinicians.
-) Confirm they are satisfied that there is not a need for wider public consultation.
-) If further consultation is required, direct the Programme to what level of consultation would need to take place and within what timeframe.

3.0 RESOLUTIONS OF THE JHSC ON 14 NOVEMBER 2018

1. That the JHSC agree that scale of change to the service is not substantial in view of the low numbers of patients.
2. That the JHSC note that the new Model of Care was designed and developed in consultation with patient and their families and clinicians.
3. That the JHSC agree the proposed new Model of Care will meet the needs of patients and significantly improve patient outcomes.
4. That the level of public and patient engagement has been proportionate and therefore the JHSC agree that there is no need for wider public consultation. That it also be noted that the details of public engagement as set out in the report will continue as the model is taken forward to implementation.
5. That it be agreed that the GM JHSC will receive a report on the progress in relation to travel analysis (initial travel analysis circulated on Monday 12th November) and equality impact assessment.
6. That the GM JHSC receive a report on Neuro-Rehab Community Services at their next meeting.
7. That the GM JHSC receive further regular updates on this Programme either formally in meetings or via email, and members are invited to a workshop to give the opportunity to increase their wider understanding of the Programme.

The resolutions are also provided in Appendix 2.

4.0 SUMMARY OF TRAVEL ANALYSIS AND EQUALITY IMPACT ASSESSMENT

4.1 Travel Analysis

An initial travel analysis developed by McKinsey & Co. has been completed and is being validated by Transport for Greater Manchester as our specialist GM partner organisation. The initial analysis was presented to the JHSC on 14 November 2018.

The key points of the initial travel analysis are:

-) As the new Model of Care does not propose that current inpatients within the NHS in GM will move to a different site – or that those currently receiving care inpatient care in the independent sector would move to a different site, it can be concluded that the journey times would relate to new patients.
-) It can also be concluded that there will be reductions in journey times as result of implementing a new Model of Care which provides inpatient care in the NHS within GM with only very occasional exceptions.
-) Four types of travel analysis were undertaken to determine the impact on changes to journey times to the three post-acute care sites.
-) The four types of method of travel were:
 - o Peak car travel
 - o Off peak car travel
 - o Off peak public transport travel
 - o Peak public transport travel
-) Additional travel time to sites which are not the closest to each Lower Super Output Area have been estimated.
-) Estimated additional minutes of journey time for travel to the other sites as ranging from 6 to 20 additional minutes for 50% of all journeys by any method and between 5 and 17 additional minutes for up to 95% of all journeys by any method.

GM Healthwatch have also agreed to undertake 'lived experience' journeys as part of our triangulated approach to understand patient, carer, staff travel and transport impacts.

4.2 Actions required for Travel Analysis

This work will now be concluded in early 2019 and be shared with the JHSC and with the JCB.

4.3 **Equality Impact Assessment (EIA)**

External experts have been brought into support the Programme team in undertaking Equality Impact Assessments for all workstreams.

The purpose of this section is to provide a summary of the travel analysis and its impacts on equality issues in regards to meeting the duties relating to Section 149 of the Public Sector Equality Duty outlined within the 2010 Equality Act.

4.3.1 The Equality Impact Assessment (EIA) addresses the new model of care, the demographics (age, ethnicity, gender and deprivation) of patients accessing services.

Table 1 below is a 'differential impact table' which links protected characteristics to potential issues linked to travel that may affect them and their support needs.

The primary source of 'consultation feedback' was from 'patient groups'.

Table 1.

Protected Characteristic	Issue	Remedy/Mitigation
<p>Age</p>	<p>The majority of neuro-rehab service users are aged 50 and above. There are a slightly higher proportion of male service users compared to females</p> <p>Older people (in particular women/widows) are more reliant on public transport.</p>	<p>Participation by different age groups shows support for the reconfiguration. Public transport during peak time is typically used by students and commuters. Outside of this, transport users are typically women; older women and mums with children and toddlers. Older patients can mean that they have older wife/husband/partners potentially relying on public transport.</p> <p>Neuro-rehab: -Where patients are being visited and are incurring long travel times the unit needs to support key family/loved ones in travel needs. There is a 'Health care travel costs scheme' (HCTRS) which allows key visitors to patients to claim for 'reasonable travel cost'. The unit needs to consider how it can support key patient visits with costs of travel and possibly taxi fares for those who live on the boundaries of GM and are incurring long travel times.</p>

<p>Disability - Linking to section 20. 'reasonable adjustments for people with disabilities.'</p> <p>N.B. Carers of people with disabilities are counted in the classifications of 'disability'</p>	<p>Carers and loved ones who have disabilities that rely on public travel will face difficulties and may have additional pressures when visiting patients.</p> <p>Disabilities can range from physical disability, learning disability, sensory impairment.</p> <p>Cancer patients are counted under the Equality Act 2010 as having a disability.</p> <p>Facial disfigurement is counted under the equality act 2010 as having a disability.</p>	<p>Particular care needs to be given for people with disabilities, visiting loved ones on the unit. Whilst many people with disabilities may have a 'blue badge' or a car through mobility benefits, so close car parking will be necessary, not all disabled people have a private car and rely on taxis and/or public transport. People with disabilities who are new to the hospital and are visiting loved ones they may find it more difficult to travel and may rely more on taxis. The unit will, have to look at how it can help support patients to claim for cost incurred through extra travel via the HCTRS.</p> <p>Similarly, if they use public transport, it may take them longer to travel on top of the already extended travel times, especially if it means having to change/transfer to joining buses/routes, learn new routes and to scope out new routes, to make it to particular rehab units. Loved ones visiting patients with sensory impairments (e.g. partial or non-sighted) may find the task of learning new bus routes and familiarising themselves with new buildings extremely difficult; they may need support in mapping out routes and how to access sites.</p> <p>Visitors with learning disabilities might find they need support in route mapping and having instructions written down. As such all this has to be taken in to consideration by the unit when considering visitation, especially visitation which helps the patient along their developmental process. The unit may have to consider special arrangements for Patient Transport Services and/or HCTRS.</p>
<p>Gender reassignment</p>	<p>No specific evidence available for this group.</p>	<p>No replies received where identified as coming from trans groups/patients or any group representing trans interests</p>

Pregnancy & maternity	No specific evidence available for this group.	No replies received were identified as coming from women who were pregnant at the time of visiting relatives in the unit or from any group that represents pregnant women's interests. With 50% of GM travellers facing a 2hrs public transport travel time this could have a significant impact on women who are heavily pregnant or suffering from symptoms related to pregnancy. The unit may need to look at ways of supporting visits by pregnant loved ones, especially if it is integral to the patient's recovery. Public transport may not be an option in some instances and the unit may have to look at taxis' reimbursement cost and where applicable look at HCTRS.																								
Race	<p>BAME patients clearly show up in the service user data. In patients (2015/16 & 2016/17)</p> <table border="1" data-bbox="432 936 783 1167"> <thead> <tr> <th>Ethnicity</th> <th>Unique Patients</th> </tr> </thead> <tbody> <tr> <td>Asian</td> <td>48</td> </tr> <tr> <td>Black</td> <td>33</td> </tr> <tr> <td>Mixed</td> <td>8</td> </tr> <tr> <td>Other</td> <td>9</td> </tr> <tr> <td>Total</td> <td>98</td> </tr> </tbody> </table> <p>Outpatients (2015/16 & 2016/17)</p> <table border="1" data-bbox="432 1272 783 1503"> <thead> <tr> <th>Ethnicity</th> <th>Unique Patients</th> </tr> </thead> <tbody> <tr> <td>Asian</td> <td>189</td> </tr> <tr> <td>Black</td> <td>46</td> </tr> <tr> <td>Mixed</td> <td>20</td> </tr> <tr> <td>Other</td> <td>24</td> </tr> <tr> <td>Total</td> <td>279</td> </tr> </tbody> </table>	Ethnicity	Unique Patients	Asian	48	Black	33	Mixed	8	Other	9	Total	98	Ethnicity	Unique Patients	Asian	189	Black	46	Mixed	20	Other	24	Total	279	<p>Whilst Manchester is a multicultural city there are geographic areas that have large numbers of particular ethnicity/faith groups. No replies received were identified as coming from BAME patients or BAME loved ones/carers visiting patients in the unit or from any group that represents BAME interests.</p> <p>In relation to public transport there is risk of hate crime.</p> <p>Race hate crimes on public transport nationally jumped from 1,453 to 2,566 over the five-year period.</p> <p>TfGM has confirmed approximated numbers for Hate Crime on Public Transport around 100 per year on the GM public transport network that caters for around 240 million journeys per year.</p> <p>The unit needs to support key family/friends who are fearful of using public transport to visit loved ones.</p>
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Religion and belief	No specific evidence available for this grouping	<p>No replies received were identified as coming from patients or loved ones visiting patients in the unit with religious /beliefs or from any group that represents different religious and belief needs.</p> <p>In relation to public transport there are risks of hate crime, TfGM has confirmed approximated numbers for Hate Crime on Public Transport around 100 per year on the GM public transport network that caters for around 240 million journeys per year.</p> <p>The unit needs to support key family/friends who are fearful of using public transport to visit loved ones.</p>				
Sex (M/F)	<table border="1"> <thead> <tr> <th data-bbox="432 842 624 887">Males</th> <th data-bbox="624 842 815 887">Females</th> </tr> </thead> <tbody> <tr> <td data-bbox="432 887 624 943">1453</td> <td data-bbox="624 887 815 943">1786</td> </tr> </tbody> </table>	Males	Females	1453	1786	The patient groups had both male and female feedback. There was support for change and no issue was highlighted that linked to male/female protected characteristics.
Males	Females					
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Sexual orientation	No specific evidence available for this groups	<p>No replies received were identified as coming from patients or loved ones visiting patients in the unit with specific sexual orientation or from any group that represents LGBT interests. The number of gay, lesbian or bisexual victims on the bus and rail network trebled from 139 to 416, over the five-year period.</p> <p>In relation to public transport there are risks of hate crime. TfGM has confirmed approximated numbers for Hate Crime on Public Transport around 100 per year on the GM public transport network that caters for around 240 million journeys per year.</p>				

4.4 Actions for the new Neuro-Rehab service linked to equality implications

1. The units continue to deliver high quality service and continues to place the patients and key visitors at the heart of the patient's recovery.
2. Units to review how it supports key visitors to the patients by offering advice with travel PTS and HCTCS and ensuring those pathways for support are known to patients.

3. The units start to record how key visitors travel to see patients, noting in particular public transport use and any difficulties with public transport (Time/cost/delays/ cancellation of key routes). After 12 months review the data, if the data shows that some visitors are having great difficulty, especially linked to disability, then the unit to consider how more immediate support can be given (e.g. taxi service)
4. The unit to review its equality policy and how it supports different protected characteristics and their needs, especially trans patients. Link with key community groups for their input and update policy and practice where necessary.
5. Link, as part of evidence gathering, with the Mayor of Manchester's campaign to bring all bus companies back in to one service provision.

5.0 NEXT STEPS

Subject to JCB consideration, the next steps in Quarter 4 of 2018/19, are proposed as:

1. JCB to determine a process to identify a lead provider
2. JCB to determine a process to identify a lead commissioner
3. JCB to determine sites for acute bed-based Neuro-Rehabilitation services
4. JCB to determine the requirements of a business case for the service

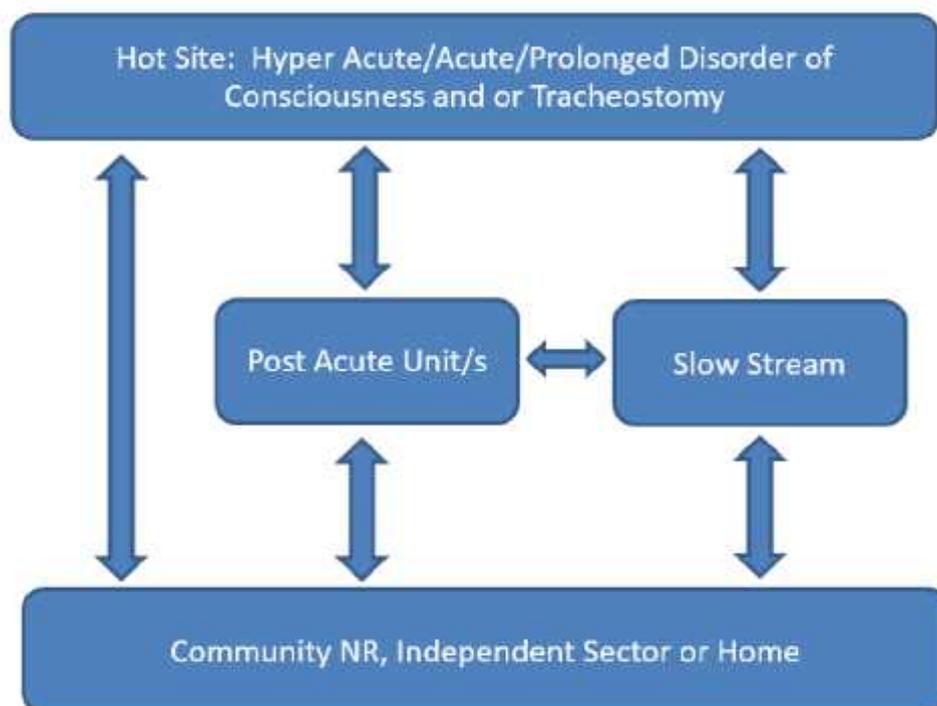
APPENDIX 1 SUMMARY OF THE NEW RECOMMENDED MODEL OF CARE FOR NEURO-REHABILITATION SERVICES

A Model of Care defines how services are organised to deliver optimal patient pathways in order to deliver improved outcomes for patients. This document describes the recommended Model of Care for Greater Manchester (GM) Neuro-Rehabilitation Services.

The Model of Care for GM Neuro-Rehabilitation (Figure 1) has been designed to meet the needs of patients and the service as described within the Case for Change Proposal by:

-) Developing a single provider model with single commissioning arrangements;
-) Delivering the service to agreed standards and with the agreed adjacent clinical co-dependent services;
-) Implementing a complex discharge team pan-GM (already approved);
-) Providing single managed care of patients with a neurological condition and a tracheostomy and/or Prolonged Disorder of Consciousness (PDoC);
-) Improving commissioning arrangements for case by case patients;
-) Commissioning and providing Community Neuro-Rehabilitation services according to the GM Community Neuro-Rehabilitation Service Specification in every locality of GM; and
-) Developing a clinical governance structure to oversee the whole of the Neuro-Rehabilitation pathway.

Figure 1: Model of Care



The key features of the Model of Care are:

- J A single provider of the bed based (inpatient) GM Neuro-Rehabilitation service to
 - o Establish a single point of access to inpatient services coupled with the complex discharge service, to implement clear admission criteria and proactively manage discharges;
 - o Support patients to be cared for closer to home, by reducing time spent in a hyper-acute environment.
 - o Improve compliance with clinical standards and eliminate the variation;
 - o Improve recruitment and retention of staff - there will be greater carer progression opportunities and improved service resilience.
- J As now, up to 30 hyper-acute and acute Neuro-Rehabilitation beds on the hot site;
- J In addition, up to 10 beds for the management of patients with tracheostomy and/or PDoC on the hot site (as an alternative to beds in the independent sector);
- J Post-acute site/s delivering up to a total of 60 beds (27 fewer beds than the current model) with the potential to reduce bed numbers further over time;
- J Circa 20 new beds for patients requiring slow stream Neuro-Rehabilitation, creating new beds closer to home for the benefits of patients.
- J Community Neuro-Rehabilitation services in every locality area providing patients with a consistent service offer, regardless of postcode; and
- J Consistent oversight, commissioning and review of all patients in ad hoc placements in the independent sector.
- J Robust and consistent pathways for patients in transition from children to adult services within Neuro-Rehabilitation.

The Model of Care, together with the clinical, community and patient experience standards and the clinical co-dependency framework will form the basis of the Neuro-Rehabilitation inpatient service specification for GM; the community Neuro-Rehabilitation service specification has already been developed in consultation with commissioners.

APPENDIX 2 DECISIONS AGREED BY THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE ON THE 14 NOVEMBER 2018

Agenda Item 4. STANDARDISING ACUTE AND SPECIALISED CARE PROGRAMME – NEURO REHABILITATION SERVICES

Resolved /-

1. That the JHSC agree that scale of change to the service is not substantial in view of the low numbers of patients.
2. That the JHSC note that the new model of care was designed and developed in consultation with patient and their families and clinicians.
3. That the JHSC agree the proposed new model of care will meet the needs of patients and significantly improve patient outcomes.
4. That the level of public and patient engagement has been proportionate and therefore the JHSC agree that there is no need for wider public consultation. That it also be noted that the details of public engagement as set out in the report will continue as the model is taken forward to implementation.
5. That it be agreed that the GM JHSC will receive a report on the progress in relation to travel analysis (initial travel analysis circulated on Monday 12th November) and equality impact assessment.
6. That the GM JHSC receives a report on Neuro-Rehab Community Services at their next meeting.
7. That the GM JHSC receive further regular updates on this theme 3 either formally in meetings or via email, and members are invited to a workshop to give the opportunity to increase their wider understanding of theme 3.