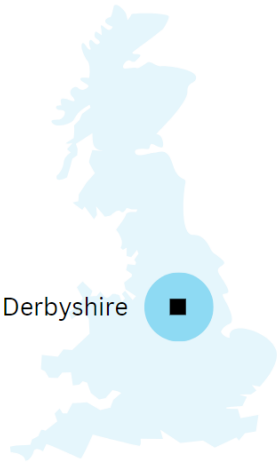
Derbyshire Integrated Care System: Improving services through mapping provision across the ICS

What is this case study about?

This case study shows how Palliative and End-of-Life Care (PEoLC) service providers from the NHS and charity sector across Derbyshire are working together to map service provision across the county, so that gaps in provision can be properly understood and addressed. This illustrates the Sue Ryder and sector partners recommendation:

"Each Integrated Care System (ICS) should centralise the data collected within their systems in order to support an ICS-wide understanding of PEoLC needs and improve the knowledge that innovations and service adaptations are built on."



Mapping PEoLC services in Derbyshire

Modelling of PEoLC services in Derbyshire had indicated that capacity and demand were fairly well matched - but this did not reflect the experiences of services on the ground, who were finding that demand was outstripping provision.

Working collectively as a system, Derbyshire wanted to answer the question: do we have the right number of services, but in the wrong places?

In order to do this, Derbyshire embarked on a new mapping process, developing a template to transparently share provider data for the first time, in order to find gaps in services and develop commissioning plans to match local population need with service provision.

"We are navigating this new system where it's not just left to the commissioner to make decisions on their own, but where we are doing this in partnership with everyone."

Uzma Rani, Commissioning Manager, NHS Derby and Derbyshire Integrated Care Board

Data transparency for shared commissioning

Previously there were four different Clinical Commissioning Groups (CCGs) covering the Derbyshire area, but these are now combined into one ICS.

The **differences in population and demographics** across the area are quite vast, covering both inner city and very rural communities. Previous commissioning from the four CCGs were based on the end of life needs of the populations of those very different areas. With the ICS covering the whole area, there was an opportunity to have a **wider overview** and commission PEoLC services with confidence that the services are where they are needed.

Modelling PEoLC capacity and demand

In order to understand the current PEoLC service landscape, Derbyshire used an existing capacity and demand modelling framework for PEoLC. This modelling suggested that the demand and capacity was well matched, but local PEoLC providers were finding that capacity was outstripping demand.

The group therefore developed its own template to **map local provision** with more accuracy and transparently share data in a way that had not been done before: mapping capacity, funding streams, voluntary resources, patient numbers, diagnosis, demand and capacity.

Derbyshire's top tips for collaboratively mapping provision

- ✓ **Take time and effort to build relationships.** Don't just see people once a month at meetings - build relationships one-to-one outside of meetings. This helps providers and commissioners develop relationships and raise things that they might not raise elsewhere – enabling problem solving together.
- ✓ **Delegate the work to people with enthusiasm and the right skill sets.** This mapping work is being led by colleagues from University Hospitals of Derby and Burton NHS Foundation Trust who had the knowledge, understanding and willingness to take it forward for the system.
- ✓ **Crowd-source knowledge and solutions:** In developing a local solution Derbyshire worked collectively as a system, involving commissioners, Public Health, acute providers, hospices, community services and Business Intelligent units. This gives everyone a chance to contribute their knowledge of how the system is working.
- ✓ **Do your homework:** Don't just jump in with good intentions: prepare first by properly understanding your services and population. Modelling local capacity and demand using an existing framework helped lay the foundations for properly understanding the local situation.

> Developing relationships and transparency through the EoL Board means that the EoL community feels much more confident.
>
> Hard commissioning decisions have been met with views from the hospices that have been critical but compassionate - fair challenges. There is a safety now in being able to review business cases together, asking questions and giving feedback.
>
> This is allowing us to make some difficult delivery decisions together that will ultimately enable us to do more.

Louise Swain, Assistant Director
NHS Derby and Derbyshire Integrated Care Board

Governance at a glance:

- This work is led by the **End-of-Life Programme Board**: a delivery board that sits under the Integrated Place Executive (which oversees all ICS place-based Alliances, and reports into the Integrated Care Board).
- The End-of-Life Programme Board is **multi-sector** and comprises health, social care and the **hospices**, who all have a seat on the board and are represented by their CEOs or Clinical Directors.
- The **data mapping process** is being led by University Hospitals of Derby and Burton NHS Foundation Trust, the local acute trust who also provide hospice services.

For more information about this case study or the recommendations for commissioning and delivering better end-of-life care, contact john.kemp@sueryder.org.

Palliative and End-of-Life Care: best practice case studies

Sue Ryder and sector partners working in PEoLC have developed **Key recommendations for commissioning and delivering better end-of-life care within Integrated Care Systems**.

This case study from Dorset is one of a series showcasing how ICSs around the country are implementing some of these recommendations:

- ✓ **Well-functioning collaboratives**
- ✓ **Local solutions to workforce challenges**
- ✓ **Engagement with patients, families & communities**
- ✓ **Measuring population need for PEoLC**
- ✓ **Innovative services and roles**