Phil Norrey
Chief Executive

To: The Chairman and Members of the Health and Adult Care Scrutiny Committee

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

(See below)

Your ref :
Our ref :

Date : 9 June 2017
Please ask for : Gerry Rufolo 01392 382299

Email: gerry.rufolo@devon.gov.uk

HEALTH AND ADULT CARE SCRUTINY COMMITTEE

Monday, 19th June, 2017

A meeting of the Health and Adult Care Scrutiny Committee is to be held on the above date at 2.15 pm at Committee Suite - County Hall to consider the following matters.

P NORREY
Chief Executive

A G E N D A

PART 1 - OPEN COMMITTEE

1 Apologies

2 Minutes

Minutes of the meeting of the Health and Wellbeing Scrutiny Committee held on 7 March 2017 and the People's Scrutiny Committee held on 20 March 2017 (previously circulated)

3 Items Requiring Urgent Attention

Items which in the opinion of the Chairman should be considered at the meeting as matters of urgency.

4 Public Participation

Members of the public may make representations/presentations on any substantive matter listed in the published agenda, as set out hereunder, relating to a specific matter or an examination of services or facilities provided or to be provided.

MATTERS FOR CONSIDERATION OR REVIEW

5 Terms of Reference of Scrutiny Committees, Cabinet Member Remits and co-ordination of Scrutiny Activity (Pages 1 - 2)

The Scrutiny Committees' current Terms of Reference are attached for information.

6 Your Future Care Proposals (Eastern Locality) (Pages 3 - 34)

Report of the NEW Devon Clinical Commissioning Group and correspondence with the Committee, attached

7 The Better Care Fund: Allocation of Additional Social Care Funding (Pages 35 - 42)

Report of the Head of Adult Commissioning and Health, DCC and the Director of Strategy, NEW Devon and South Devon and Torbay (ACH/17/68), attached

8 Election of Commissioning Liaison Member

In line with the recommendations of the 'Scrutiny in a Commissioning Council' Task Group Report, the Committee be asked to select a Commissioning Liaison Member, whose role will be to work closely with the relevant Cabinet Members and Chief Officers/Heads of Service, developing a fuller understanding of commissioning processes, and provide a link between Cabinet and Scrutiny on commissioning and commissioned services.

The Commissioning Scrutiny Task Group Report can be viewed here:

http://democracy.devon.gov.uk/documents/s1830/Scrutiny%20in%20a%20Commissioning%20Council.pdf

9 Work Programme: Draft (Pages 43 - 46)

In accordance with previous practice, Scrutiny Committees are requested to review the forthcoming business and determine which items are to be included in the Work Programme, draft work plan attached.

The Committee may also wish to review the content of the Cabinet Forward Plan to see if there are any specific item therein it might wish to explore further.

The Work Programme and Forward Plan can be found at:

http://democracy.devon.gov.uk/mgPlansHome.aspx?bcr=1

MATTERS FOR INFORMATION

10 Information Previously Circulated

Below is a list of information previously circulated for Members, since the last meeting, relating to topical developments which have been or are currently being considered by this Scrutiny Committee.

Nil

PART II - ITEMS WHICH MAY BE TAKEN IN THE ABSENCE OF PRESS AND PUBLIC ON THE GROUNDS THAT EXEMPT INFORMATION MAY BE DISCLOSED

Nil

Members are reminded that Part II Reports contain confidential information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s).
Members are also reminded of the need to dispose of such reports carefully and are therefore invited to return them to the Democratic Services Officer at the conclusion of the meeting for disposal.

Membership

Councillors S Randall-Johnson (Chairman), N Way (Vice-Chair), H Ackland, J Berry, P Crabb, R Gilbert, B Greenslade, R Peart, Y Russell, P Sanders, R Scott, J Trail, P Twiss, C Whitton, C Wright, J Yabsley

Representing District Councils
Councillor P Diviani

Declaration of Interests

Members are reminded that they must declare any interest they may have in any item to be considered at this meeting, prior to any discussion taking place on that item.

Access to Information

Any person wishing to inspect any minutes, reports or lists of background papers relating to any item on this agenda should contact Gerry Rufolo on 01392 382299.
Agenda and minutes of the Committee are published on the Council's Website and can also be accessed via the Modern.Gov app, available from the usual stores.
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The proceedings of this meeting may be recorded for broadcasting live on the internet via the 'Democracy Centre' on the County Council's website. The whole of the meeting may be broadcast apart from any confidential items which may need to be considered in the absence of the press and public. For more information go to: http://www.devoncc.public-i.tv/core/

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Members of the public may also use Facebook and Twitter or other forms of social media to report on proceedings at this meeting. An open, publicly available Wi-Fi network (i.e. DCC) is normally available for meetings held in the Committee Suite at County Hall. For information on Wi-Fi availability at other locations, please contact the Officer identified above.

Public Participation

Devon's residents may attend and speak at any meeting of a County Council Scrutiny Committee when it is reviewing any specific matter or examining the provision of services or facilities as listed on the agenda for that meeting.

Scrutiny Committees set aside 15 minutes at the beginning of each meeting to allow anyone who has registered to speak on any such item. Speakers are normally allowed 3 minutes each.

Anyone wishing to speak is requested to register in writing to the Clerk of the Committee (details above) by the deadline, outlined in the Council's Public Participation Scheme https://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/, indicating which item they wish to speak on and giving a brief outline of the issues/ points they wish to make.

Alternatively, any Member of the public may at any time submit their views on any matter to be considered by a Scrutiny Committee at a meeting or included in its work Programme direct to the Chairman or Members of that Committee or via the Democratic Services & Scrutiny Secretariat (committee@devon.gov.uk). Members of the public may also suggest topics (see: https://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/scrutiny-work-programme/

All Scrutiny Committee agenda are published at least seven days before the meeting on the Council's website.

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If you need a copy of this Agenda and/or a Report in another format (e.g. large print, audio tape, Braille or other languages), please contact the Information Centre on 01392 380101 or email to: centre@devon.gov.uk or write to the Democratic and Scrutiny Secretariat at County Hall, Exeter, EX2 4QD.

Induction loop system available

NOTES FOR VISITORS

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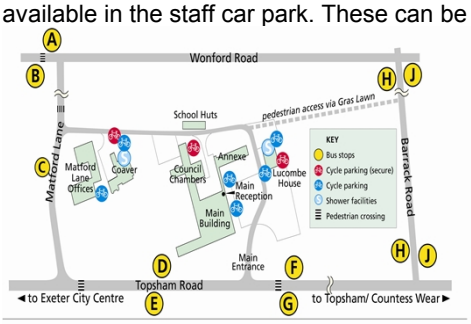

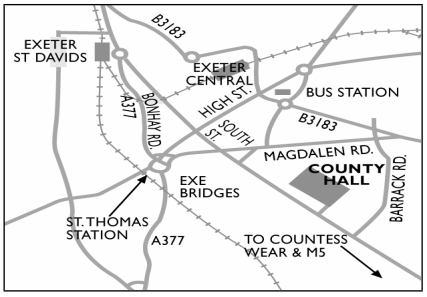

NB (A) (J) **Denotes bus stops**

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First Aid

Contact Main Reception (extension 2504) for a trained first aider.

EXTRACT FROM THE COUNTY COUNCIL'S CONSTITUTION

9.2 Corporate, Infrastructure and Regulatory Services Scrutiny Committee

(1) To review the implementation of the Council's existing policy and budget framework and ensure effective scrutiny of the Council's Treasury Management Strategy and policies and consider the scope for new policies for the Council's use and management of its resources and the discharge of its corporate and strategic services and governance arrangements and community safety activity, including emergency planning 30 and the Council's functions in the scrutiny of authorities responsible for crime and disorder strategies;

(2) To review the implementation of existing policies and to consider the scope for new policies with regard to all aspects of the discharge of the Council's 'place shaping and universal population services' functions concerning the environment, economic activity and enterprise, integrated planning and transport and community services, including libraries, arts and cultural heritage of the County, an integrated youth service and post 16 education & skills;

(3) To assess the effectiveness of decisions of the Cabinet in these areas of the Council's statutory activity and relate overview and scrutiny to the achievement of the Council's strategic priorities and objectives and of delivering best value in all its activities;

(4) To make reports and recommendations as appropriate arising from this area of overview and scrutiny.

9.3 Children's Scrutiny Committee

(1) To review the implementation of existing policies and to consider the scope for new policies for all aspects of the discharge of the Council's functions concerning the provision of personal services for children including social care, safeguarding and special needs services, schools and learning;

(2) To assess the effectiveness of decisions of the Cabinet in these areas of the Council's statutory activity;

(3) To relate scrutiny to the achievement of the Council's strategic priorities and objectives and of delivering best value in all its activities;

(4) To make reports and recommendations as appropriate arising from this area of overview and scrutiny.

9.4 Health & Adult Care Scrutiny Committee

(1) To review the implementation of existing policies and to consider the scope for new policies for all aspects of the discharge of the Council's functions concerning the provision of personal services for adults including social care, safeguarding and special needs services and relating to the health and wellbeing of the people of Devon, including the activities of the Health & Wellbeing Board, and the development of commissioning strategies, strategic needs assessments and, generally, to discharge its functions in the scrutiny of any matter relating to the planning, provision and operation of the health service in Devon;

(2) To assess the effectiveness of decisions of the Cabinet in these areas of the Council's statutory activity;

(3) To relate scrutiny to the achievement of the Council's strategic priorities and to its objectives of promoting sustainable development and of delivering best value in all its activities;

(4) To make reports and recommendations as appropriate arising from this scrutiny to the County Council and to the Secretary of State for Health, in accordance with the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Report to Devon Health and Adult Care Scrutiny Committee
19th June 2017

Your Future Care

Recommendation

The Devon Health and Adult Care Scrutiny committee is asked to note the content of this report which provides an update in relation to the Your Future Care consultation.

1. Context

This paper has been prepared for the Devon Health and Adult Care Scrutiny Committee. It provides background information to the *Your Future Care* programme and decisions made by NHS Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) Governing Body of 2nd March 2017, following public consultation, to reduce community hospital inpatient beds and units in the Eastern locality in the context of developing a new model of care for the area.

This programme is designed to deliver improved outcomes and experiences for patients, improved experiences for staff and clinical and financial sustainability of community services.

Since the CCG's Governing Body decision, the CCG has been working closely with colleagues at the Royal Devon and Exeter NHS Foundation Trust and Devon County Council to prepare for effective and phased implementation of the changes.

The CCG recognises that the Devon Health and Wellbeing Scrutiny Committee raised specific questions and concerns through a resolution made on 7th March 2017. The CCG has responded to correspondence from that Committee. In the intervening period progress has been made in the detailed preparations and engagement for implementation as described in this paper.

2. Background

The CCG originally began reviewing community services in North, East and West Devon in 2013, developing and approving 'Integrated, personal and sustainable: Community services for the 21st Century' in 2014. This strategic framework was based on engagement throughout the area and set the early foundations for changing the model of care towards preventive, pro-active and co-ordinated care outside of hospital, where possible.

Building on this, in 2016 further engagement of clinicians resulted in recommendations to further shift the emphasis from bed based care to more effective, reliable and sustainable models of home-based model, which is designed to offer:

- Comprehensive assessment:
- Single point of access:
- Rapid response:

Comprehensive assessment identifies people who are at risk and assesses and plans their care with them when they are not in crisis. The single point of access provides a contact point for professionals to achieve an urgent response for the patient. Rapid/urgent response, which includes rapid access to a specialist opinion, institutes a package of care for the person to help them remain at home where possible.

The level of community hospital inpatient provision is notably higher in Eastern Devon than in Northern and Western and key to the proposal was that inpatient beds in Eastern Locality reduce from 143 to 72, a level more comparable with current inpatient levels in Northern and Western Localities. Public consultation took place between 7th October 2016 and 6th January 2017 (13 weeks).

In preparing for public consultation, the CCG's process was subject to external assurance by NHS England, in accordance with the four tests of service change and requirements set out in *'Planning, Assuring and Delivering Service Changes for Patients'* [1]. As part of this external assurance the proposals were reviewed by the South West Clinical Senate, who also supported the decision to proceed to public consultation, whilst noting areas for attention in implementation.

[1] Planning, assuring and delivering service changes for patients: NHS England (2015) https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

The outcomes of public consultation report have previously been provided to the Scrutiny Committee including the full post-consultation report in March 2017. There was considerable feedback with recurrent themes incorporating: local impact; travel; rurality; staffing the new model; quality and safety; impact on individuals; finance; future proofing of services. The post-consultation report is available on the CCG website here.

Whilst the consultation sought feedback on the four most viable inpatient configuration options (with the option to suggest alternatives to meet the decision criteria), the process that followed included further review and analysis in light of public consultation before making the recommendation to the CCG's Governing Body to close inpatient beds in Exeter, Honiton, Seaton and Okehampton community hospitals and to proceed to develop the new model of care.

The consultation and subsequent decision took place soon after the CCG finalised the re-procurement of community services, including services in community hospitals. Royal Devon and Exeter NHS Foundation Trust started running the services from 1st October 2016 following a process designed to strengthen community based services for the population in Eastern Locality. RD&E has been engaging with local stakeholders, consulting with their staff and actively preparing for implementation by autumn 2017.

3. Governing Body decision

As well as recommending the locations for inpatient beds, the CCG's Governing Body also identified the importance of ensuring readiness for implementation. Therefore, the following arrangements have been put in place:

- **CCG/RD&E Clinical and Professional reference group:**
  This group is designed to bring together clinicians and professionals to support the detailed planning of implementation, in particular by seeking to understand the particular needs of communities affected by the changes and clarifying the future provision in these towns. Particular focus and work on understanding the needs of the populations of Okehampton and Axminster is being undertaken.

- **CCG Implementation Assurance Panel:**
  This clinically chaired group is mandated by the CCG's Governing Body to assure readiness for implementation. It is a formal group reporting back to the CCG Executive and onward to the CCG's Governing Body. It will meet three

times ahead of implementation in September and October this year to review the implementation plans against a series of gateway questions, which span the following parameters:

- Pre-implementation
- Workforce
- Governance, communication and engagement
- Implementation
- Post implementation

The questions identified for each of these parameters are designed to achieve safe and quality implementation. Examples of these gateway questions are:

- Implementation: Are the needs of people requiring palliative and terminal care planned for? What is the availability of alternatives and impact on social care?

- The workforce: Is there a clear understanding of and plan for the workforce and any changes required in ways of working?

- Governance: Is there a clear roll out plan for implementation that has due regard to the operational issues of managing change?

These and other gateway questions take into account key themes raised by clinicians and the public and include: readiness of the workforce; preparedness of the new model; implications for social care; and end of life care. The panel will also consider the recommendations of the South West Clinical Senate for implementation.

The CCG has been clear that no beds will permanently close until it is assured of readiness. This panel process is designed to provide this assurance.

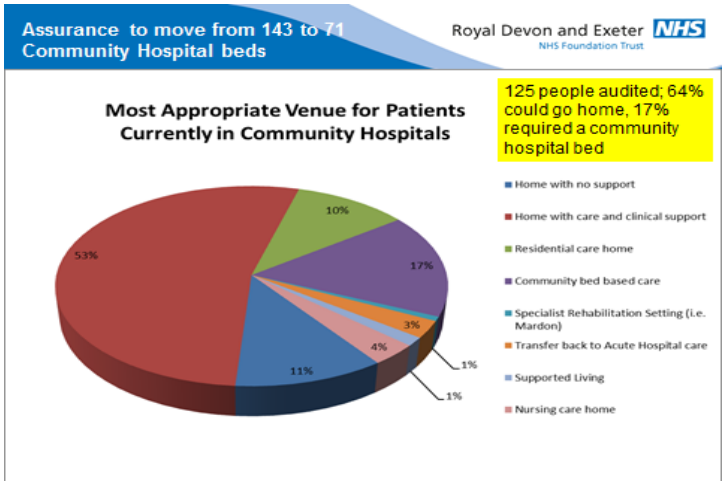
4. Implementation to date

The decision making business case (DMBC) considered by the CCG's Governing Body (available here) estimated that in a given week about 30 patients are admitted to the seven community hospitals with inpatient beds in the Eastern Locality.

For all four hospitals that will no longer have inpatient beds, this is 15-20 admissions a week, of which two thirds are expected to be treated at home once the new model is in place. Where patients have a clinical need for a hospital inpatient stay, this will continue to be available to them.

Since then the following additional work has been undertaken:

- An audit conducted in March 2017 of 125 patients in the 7 current inpatient units showed that 64% of these patients could be supported at home (11% without additional support and the remaining 53% with additional care). The percentage who were assessed as requiring community hospital care was 17%.



- Local community services managers and teams have worked with local stakeholders at workshops to model and explore the requirements for each area, in order to support people outside of these hospital settings. These workshops have been positively received. This modelling recognises that each local area is at different starting points and is tailoring services to address this. The detailed staffing structures to deliver the new model and how this works in practice are developing well.

- Workforce consultation commenced on 15th May 2017 for a three month consultation period, which is important in involving and preparing staff for the future. This process is being conducted by RD&E working with the staff side representatives. Staff meetings have started for groups of staff and also 1-1 meetings are being held to support staff in the transition. The change affects 200 directly affected and partially affected staff members and there are a variety of employment opportunities to ensure that we retain the skills of our valuable workforce within our health and social care system.

The change to each of the inpatient units and operationalisation of the new model will take place in a phased way. At the present time the indicative schedule, noting this may be subject to change, is that Exeter and Honiton inpatient beds will close in September 2017 and Seaton and Okehampton in October 2017.

The CCG and the provider are clear on the importance of effective measures to evaluate services post implementation and building on the advice of the Devon Health and Wellbeing Scrutiny Committee Quality Spotlight review (2017) from the point of implementation, the CCG and provider will ensure the services deliver the desired outcomes. They will share performance reports with the Committee.

5. Next steps

This report is in addition to the CCG's responses to the Committee resolution previously provided and therefore does not duplicate the detail here, although the CCG recognise this will be discussed at Committee. As progress has since been made, the CCG asks the Committee to note this report, support the progress towards the implementation and engage in future evaluation of the new care model.

Given the nature of these changes, it is recommended that the CCG and RD&E report back to the Committee at an early stage post implementation in November 2017, recognising the Committee may wish an interim report before that date.

The Your Future Care programme forms the early stages of wider development through the Devon Sustainability and Transformation Plan (STP) Integrated Care Model (ICM) programme. Spanning the areas covered by both NEW Devon and South Devon and Torbay CCGs, this will build on these initial changes and collaborate with key stakeholders to drive forward future developments in delivering person-centred, integrated care in the community.

Sonja Manton
Director of Strategy
NEW Devon Clinical Commissioning Group

Northern, Eastern and Western Devon
Clinical Commissioning Group

Cllr Sara Randall-Johnson
Chair
Health and Adult Care Scrutiny Committee
Devon County Council

06 June 2017

Dear Cllr Randall-Johnson

Your Future Care: Devon Health and Wellbeing Scrutiny Committee Resolution of 7th March 2017

I am writing in relation to the concerns raised and assurances required by the previous Health and Wellbeing Scrutiny Committee as set out in the Committee Resolution of 7th March 2017. The CCG initially responded on 7th April 2017 and the CCG received a follow up letter from Councillor Richard Westlake dated 24th April 2017. I hope this response to you in your role as Chair of the committee will be of assistance in addressing the outstanding points Cllr Westlake raised.

In summary, *Your Future Care* is focused on establishing a model of care that is designed to help people who have complex needs or are otherwise frail, to remain as well as possible for as long as possible at home. The model is focused on comprehensive assessment, a single point of access and rapid/urgent response in the community to reduce time spent in hospital and increase the likelihood of people being supported at home.

The detail is provided in previous Scrutiny papers and particularly in the CCG's decision making business case which underpinned the CCG decision to reduce inpatient beds in community hospitals in Eastern Devon from 143 to 72 and to

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Chief Officer: Janet Fitzgerald

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establish the out of hospital model of care across the area. This is the starting point to enable a shift in emphasis increasingly towards prevention, early intervention and integrated personalised out of hospital care.

Progress towards implementation is now well underway and the CCG is working closely with Royal Devon and Exeter NHS Foundation Trust, the Eastern Locality community service provider. As part of the detailed preparation for implementation the Trust recently conducted an audit that showed 64% of patients in community hospital beds at the time of the audit could have been at home (some without support but the majority with support planned in the new model).

The CCG has also engaged with Devon County Council adult social care commissioning colleagues who have responded directly to the Scrutiny resolution. We recognise changes to the care model bring uncertainty and as we have indicated in previous correspondence with the Committee the CCG is willing to fully engage in discussions and looks forward to working with you to resolve these matters.

Cllr Westlake has helpfully explained that where South Devon and Torbay CCG were able to assure the Committee, a similar set of proposals in NEW Devon did not achieve a comparable level of assurance. We greatly welcome this explanation and hope the additional information included in this letter will assist in providing further information that will assist the Committee to address the following outstanding points:

1) Implementation assurance
2) Northern Devon
3) Financial savings
4) Future of hospital buildings
5) Okehampton and Honiton Hospitals
6) Staff engagement

1) Implementation assurance: We were pleased to note that the Committee welcomed the implementation assurance process. The CCG promised during consultation that no beds would permanently close until there was assurance on readiness for implementation. 30 assurance questions were developed and approved by the Governing Body, spanning the following parameters:

- Pre-implementation
- Workforce
- Governance, communication and engagement
- Implementation
- Post implementation

The questions identified for each of these parameters are designed to achieve safe and quality implementation. A clinically chaired implementation assurance

panel, mandated by and reporting to the CCG Governing Body, now has the core responsibility to review implementation plans against the parameters. The panel will meet 3 times before implementation in September and October this year. In the interests of transparency, we would be pleased to invite you as Chair to be in attendance as an observer at panel meetings should you and the Committee consider this to be of assistance.

A copy of these parameters was previously published in the Decision Making Business Case and these are also appended to this letter (appendix 1).

2) **Northern Devon:** In relation to your question of measurable success, Northern Devon NHS Healthcare Trust has previously reported the following points of improvement: winter performance operating effectively with 47 fewer beds (across the acute and community system) in 2015/16 accompanied by fewer and shorter periods of escalation; improvement in clinical and cost efficiency, shifting resources into community services and caring for more patients; as well as demonstrating patient satisfaction. If it would be helpful to see more details of how this has been demonstrated, then please let us know and we can provide this.

3) **Financial savings:** The CCG recognises the savings proposed will be modest and agrees with the Committee's point that it is crucial to ensure the model of care can support an increasing elderly population. Building on the estimates made in your future care, RD&E has been advancing the detailed implementation planning for the new model. This plan has been developed by professionals, clinicians and managers leading or working within the services based on their assessment of requirements to implement an effective new model to support more people with complex needs at home.

In relation to your point that previously the Committee were told that changes to the model of care were relatively cost neutral, this is correct and reflects the assessment within the previous TCS process. At that time the focus was on consolidating services in fewer units with only minimal reduction in the overall bed stock as a first stage in service change. The current changes are different in that they do both reduce the number of beds and invest in the new model of care, something that was not possible in the earlier changes.

In relation to the current changes we acknowledge the understanding of the potential savings of £200-£300 per bed day which would result in gross savings of £4.7m - £7.0m. The lower end of savings represents the direct costs of the staffing and consumables to operate the inpatient beds. The upper end of savings would be available should we be able to mitigate the fixed costs of the building through alternative uses of the space freed up. Our projections for reinvestment are in the range of 20-40% and will be determined by the levels of demographic growth and complexity of need for each individual community.

These aspects are being considered by the RD&E in their detailed implementation planning which involves professionals, clinicians and managers to assess the levels of community resources necessary in each community.

With regard to the community hospital buildings and commercial property rents we can confirm that the movement to commercial rents has been fully funded by NHSE and has therefore not presented the local system with an additional financial burden. In terms of agency staff, there has been a determined effort to reduce agency use both to bring financial and continuity of care benefits. This was taken into account in contracting for Community Services with RD&E with the full year effect of savings exceeding £1m.

4) **The future of hospital buildings:** Thank you for outlining your concerns in relation to hospital buildings, many of which have benefited from financial assistance from communities. Whilst NHS Property Services owns and runs many facilities, declaration of a facility as surplus to requirements is the responsibility of the CCG. When wards are vacated of inpatient beds, the arrangement between RD&E and NHS Property Services is that responsibility for funding the void is time limited and is that of the CCG. We have planned for this. We have been clear that this particular consultation does not impact on other services in the hospitals; however we do recognise that people do want more clarity on the longer term. Although this is not available at the current time, a Devon strategic estates plan is expected to be developed in 2017/18.

5) **Okehampton and Honiton Hospitals:** It is helpful to understand the Committee's concerns in relation to the consultation document. Whilst the space on the document was short there was a clear invitation on the response form to add extra sheets if needed and many people did so. The point about other options linking to the strategic priorities was specifically intended to be of assistance to respondents. Now these specific concerns have been drawn to our attention, I can assure you they will be taken into account when preparing future consultation questionnaires and documents. We have been discussing greater collaboration between the two CCGs in future planning, engagement and consultation so there will be the benefit of shared learning. In addressing these learning points it is important to note that the CCG did receive responses for Okehampton and Honiton in the consultation as detailed in the consultation report previously submitted to the Committee.

6) **Staff engagement:** In responding to the specific point raised in the resolution I can see we have not fully explained the range of ways staff are engaged and supported. Whilst a small number of staff responded in writing to the consultation, more joined in the public consultation events and there was a range of other engagement events with staff. As you know, in 2016 the services

transferred from Northern Devon Healthcare Trust to Royal Devon and Exeter Foundation Trust. In summer last year in preparation for the transfer there were many meetings held with staff by the RD&E and these meetings did make staff aware of the Success Regime and the potential for change in community

hospitals. RD&E as employer has been engaged in the consultation and has continued to have regular communication with staff throughout the *Your Future Care* work. This has included: senior management visits to all directly impacted hospitals the day after the CCG decision; informal 1-1 meetings with staff to discuss concerns; staff meetings in hospitals; and locality workshops to work through the new model of care which have been well received.

The RD&E has now commenced the formal HR consultation process which is for a 3 month period. It is designed to provide more information and engage staff in shaping the changes as well as specifically supporting staff through the transition. This involves staff 1-1 meetings, group meetings, written materials all designed to ensure the wishes, ideas and concerns are heard. There is also emphasis on workforce in our Implementation Assurance process recognises the absolute importance of the staff team providing services now and in supporting them in the future. HR leads have also been actively working on setting out the competences needed for the future and supporting staff in the transition will be central to effective implementation.

I trust this letter is of assistance in addressing the outstanding points raised by Cllr Westlake, however as I have already indicated the CCG will welcome ongoing dialogue with you to bring these matters to a resolution. Please do not hesitate to contact me if you wish to discuss any of these points further.

Yours sincerely

Janet Fitzgerald
Chief Officer

Devon County Council

Ms Janet Fitzgerald
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Date 24th April 2017

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Dear Ms. Fitzgerald,

Thank you for your letter received on the 7th April 2017, addressing concerns raised at the Health and Wellbeing Scrutiny Committee meeting which took place on the 7th March and were detailed in my letter of the 9th March. The Committee welcomed your response within 28 days of the notification in line with regulation 22 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Members of the Health and Wellbeing Scrutiny Committee have received the information sent, but have not met to formally consider the detail due to the imminent County Council elections. This matter, its correspondence and supporting information will all be referred to the earliest meeting of a new Health Scrutiny Committee for consideration. With this in mind there nonetheless remain a number of outstanding concerns raised by the current Committee upon which I would appreciate your prompt attention and response to aid in the timely resolution of this issue.

Before addressing each point in detail, I would like to make it absolutely clear that there has not yet been a referral to the Secretary of State. In page 6 of your letter you request clarity over why NEW Devon CCG's decision was proposed for referral when decisions taken over closure of hospitals in South Devon were endorsed. The Committee does not need to defend its actions but in this instance further information and assurances were sought from NEW Devon CCG whilst the Committee felt that these had been provided by South Devon and Torbay CCG. More specific examples of how the requirements were met by South Devon and Torbay are mentioned in the content of this letter, in line with your request.

1/ The robust implementation assurance process that you will be undertaking is mentioned many times in your response including in relation to end of life care and being in line with the Government's new requirements for change. The Scrutiny Committee welcomes this approach, however without more information on what this tests or when assurance will be reached the Committee cannot accept the statement that there is an assurance process as complete assurance. Robert Francis QC made exactly this point in the review of scrutiny activities in Mid Staffordshire where there was heavy criticism of scrutiny for offering ineffective challenge. Devon County Council Health Scrutiny Committee therefore asks that you provide further evidence on what the criteria of the assurance process will be, what measures will meet the assurance criteria, and what the timescale will be.

By way of comparison South Devon and Torbay CCG detailed nine parameters that would need to be in place for community beds to be removed in their report to Committee, this provided members with much needed reassurance.

2/ The Committee have engaged in significant dialogue over the past years on the issue of success of the changes in North Devon. The Committee is aware of the reduction in A&E attendances after implementation but would like to understand the other elements of 'measurable success' (pg.3 main letter). This is even more pertinent in light of the outstanding referral to the Secretary of State on the removal of the beds at Torrington Community Hospital.

3/ The Scrutiny Committee remains concerned about NEW Devon CCG's financial position. The Committee undertook the detailed Task Group on CCG funding concluding early this year and in broad terms recommended more money should come to Devon to reflect the rural and older demographic profile.

Forecasting savings of £2.8m to £5.6m a year is of course welcome to assist the wider programme of savings. It is however difficult from high level figures to gauge how realistic it will be to achieve these savings. The Health Scrutiny Committee has been informed on a number of occasions that the changes to the model of care, with people being treated at home instead of in a community hospital, is cost neutral. The committee understands how the potential savings are reached with the reduction of 71 beds and the corresponding £200-£300 per bed day as detailed in your paperwork. However there remain concerns about the increasingly elderly population having co-morbidities and these being expensive to treat at home. At this stage there is no detail about the community hospital buildings and commercial property rents being charged. There is also the enduring concern about agency staff. It would be useful to have reassurances about these aspects of your financial forecasting.

4/ The future of hospital buildings is a particular point that causes concern. Summarising the concerns of the Committee there are two aspects. The first is what will happen to the buildings, many of which have had considerable financial assistance from the communities they are situated in. NHS Property Co. is under no requirement to reinvest in local services should the buildings be deemed to be surplus to requirements. The second point is one more of reassurance of ongoing community services, other forms of healthcare can be provided locally from a hub model. The Committee accept, having spoken to many members of the public on this issue, that there is widespread belief that closure of beds heralds closure of the hospital unless explicitly stated otherwise. Waiting on the conclusion of an estates strategy with an unknown timescale does not promote confidence. The clarity over what would happen in each location is one particular aspect that South Devon and Torbay CCS was commended upon.

5/ The exclusion of Okehampton and Honiton hospitals from the consultation process.
Once again the Scrutiny Committee welcomes South Devon and Torbay CCG's approach which was to invite members of the public to submit alternative proposals. NEW Devon had a similar option but the Committee asserts that the execution was significantly different. The consultation document from South Devon and Torbay was clearly laid out with easy to answer questions. There was an invitation for open text or an add-on if people wished to submit alternative proposals. This compares to the option for NEW Devon CCG 'Your Future Care' which required members of the public to address how their suggestion met the six strategic priorities and how it met the decision making criteria. The space provided for this was only 5 lines in the hard copy. It is the Scrutiny Committee's assertion that this represented a significant barrier for members of the public to make suggestions including those of Okehampton and Honiton. South Devon and Torbay also asked the questions about each hospital closing independently of other hospitals.

The Committee remains dissatisfied with the questions asked in the consultation.

6/ A very small proportion of staff responded to the consultation. This is severely concerning.
Your response details that out of 1400 staff less than 2% responded to the consultation (pg 8 of the responses to resolution (b)). However on page 4 of the same document you estimate that 50 staff could require redeployment as part of this decision. The Committee would like to understand if the 25 or so responses that were received from staff (<2% 0f 1400) were made up of the staff who are facing redeployment, which could be much more like 50% of the affected staff. In broader terms if

less than 2% of staff were represented in the response the committee would like greater detail on the efforts that are being made to engage with staff.

Thank you for your ongoing support and dialogue in seeking to resolve the outstanding issues on this significant programme of change. I would anticipate that consideration of your response and the correspondence to date will form one of the very first tasks that any new Health Scrutiny Chairman and Committee will undertake. Indeed I would think it was highly likely that the first meeting of the Committee will consider this matter and make a decision on the next steps.

Yours Sincerely

Councillor Richard Westlake
Chairman of the Devon County Council Health and Wellbeing Scrutiny Committee

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Councillor Richard Westlake
Chair
Health and Wellbeing Scrutiny Committee
Devon County Council

07th April 2017

Dear Councillor Westlake

NEW Devon CCG proposal on Your Future Care

I am writing in response to your letter dated 9th March 2017 following the Devon Health and Wellbeing Scrutiny Committee meeting held on 7th March 2017 at which the CCG's *Your Future Care* process and decision was reviewed.
It would be important upfront to reinforce to the Committee why the CCG is proposing a new model of care. This new model is very similar in concept to the one that was presented by South Devon and Torbay CCG that was approved at the same meeting by the Committee and supported in principle by the South West Clinical Senate.

Our rationale is that the NHS can effectively treat the same number of patients, whilst saving up to £5.6 million per annum, by introducing our new model of care. Given the pressures on the NHS in terms of growing patient demand and the current deficit of £86 million across Devon, our plans make good clinical and financial sense.

In addition, we know that where it is safe to do so, many patients would prefer to be cared for at home. Presently, in a given week, around 30 patients are admitted to the seven community hospitals with inpatient beds in the eastern locality. Of the four hospitals which will no longer have beds, this number of admissions is 15 to 20 patients per week.

Chair: Dr Tim Burke
Chief Officer: Janet Fitzgerald

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Whilst a small proportion of patients will still be cared for in a community hospital when clinically necessary, our estimate is that the majority, two thirds or 10 to 15 patients per week, will be treated in their own homes once the new model is in place. The actual numbers will, of course, be based on the assessment of each individual patient.

This represents a very small proportion of the care packages arranged for people in Eastern Devon. In any one day, thousands of patients are cared for in their own homes across Devon, an unseen yet vital service for patients. Our changes and the savings we will make are fundamental to enabling us to deliver NHS services that are clinically and financially sustainable.

Whilst we are extremely disappointed with the outcome of the meeting, we also appreciate the importance of the scrutiny role and wish to assure you that we have managed a thorough and comprehensive process for developing the *Your Future Care* proposals.

In doing so the CCG has engaged with Devon County Council and the RD&E NHS Foundation Trust, the provider of services. I will now address each of the Committee's points briefly below and overleaf. An additional Appendix is enclosed which contains more detail should the Committee require it.

a) *That this Committee object to the decision by NEW Devon CCG to reduce the number of community hospital beds in Eastern Devon from 143 to 72 and regardless of cost no bed closures be made until it is clear there was sufficient community care provision.*

With regard to the Committee's concerns about adequate provision of community services before beds are closed, the CCG has been very clear throughout the process that no beds will close until we are fully assured that it is both safe to do so and that the new arrangements are ready to care for our patients. We are currently planning the implementation of these arrangements.

The CCG has a robust implementation assurance process that will be applied throughout the transition period. Preparations have begun and we estimate that we will move to commence implementation from September this year. The assurance processes will commence well before that.

b) That, if adequate assurances are not given to the above and the issues set out below, the CCG's decision be referred to the Secretary of State for Health on the grounds that it was not in the interests of the health service in the area and the consultation was flawed.

We have provided a detailed response to each of the Committee's points in resolution b) in the attached Appendix to this letter, which I hope will be of assistance. This response has been prepared in discussion with colleagues in Devon County Council who will respond separately to the specific points where they are responsible for the provision to which you refer.

From the start of this process there has been clinical engagement and engagement of health and care organisations in the STP footprint and this will continue into implementation. The CCG has also worked with legal advisors to ensure a fair and robust process and refutes any suggestion that the consultation was in any way flawed.

In summary, our response to the main points is as follows:

- Care at home: You are aware that the changes will focus on provision of a comprehensive assessment to assess people at risk when they are not in crisis; a single point of access to services for professionals; and rapid response by community and other services to fulfil care packages required to support discharge. This model has been implemented with measurable success in Northern Devon and preparations for implementation in Eastern Devon are well underway.
- Hospiscare: Availability of adequate end of life care provision will be specifically addressed through the assurance process. Whilst the capacity of social care packages you refer to is a matter for the Council, we will ensure that both the health and social care aspects of provision are capable of meeting the needs of the affected patient group in each area before beds are closed.
- Numbers of new staff: The RD&E are currently working with locality teams to agree the requirements in each community to safely transfer people from bed-based models of care to care in their own homes. The CCG estimate is that around 50 staff could require redeployment and these staff will have valuable skills to support our community or in-patient services. The RD&E will develop a workforce plan to support the delivery of the new model of care. A consultation process is being worked through with staff-side to ensure that we retain the valuable skills of our staff who work in the in-patent units within our community.

- Financial savings: The changes will save between £2.8 million and £5.6 million a year after the investment in additional community services has been made.
- The future of hospital buildings: Although ownership of these facilities is with NHS Property Services, our services and estates strategies will inform the future of these facilities. It is important to note, however, that our decision relates to inpatient beds only at these facilities.
- Government direction and new test: Following engagement with NHS England, it is our understanding that the new test is unlikely to be applied retrospectively. However, we are confident that should the new test be applied to our proposals, the requirements would be fully met.
- Closure of care homes: The provision of social care is a matter for the Council; however our evaluation of readiness to implement will take into account availability of social care relevant to patient groups affected by the change.
- Okehampton and Honiton: Although neither of these sites featured in the four short listed sites, their suitability as options were fully evaluated along with all of the other sites in Eastern Devon within the scope of the proposals pre-consultation as referenced in the consultation documentation, and further considered post consultation before the Governing Body decision.
- Holsworthy Hospital: This is a temporary decision by Northern Devon Healthcare NHS Trust. It does not change the CCG decision in relation to Okehampton; however the impact will be considered in the assessment we undertake before Okehampton beds are closed.
- Pressure on RD&E: The new model of care is designed to relieve pressure on hospital services. The CCG is working closely with the RD&E, as they play a key role in implementing the proposals. As part of this, we will of course actively monitor discharges.
- Seaton and Sidmouth: It is worth re-emphasising that the decision to choose Sidmouth over Seaton was very finely balanced. In this context, we focussed on our specific CCG statutory duty to address population health inequalities. Since the proposals are based on a care model particularly aimed at the older population, beds are more likely to be occupied by this age group and the Sidmouth population is larger overall, it was judged that retention of beds in Sidmouth would be preferable to Seaton.
- Staff views: The CCG has actively engaged and consulted with staff, patients and the public on the proposals. There is now an additional consultation with staff directly affected, led by the RD&E.

We have taken on board the advice from previous committee meetings that it is important to be able to evaluate the impact of changes. Our Decision Making Business Case (DMBC) sets out the intent to improve outcomes and experiences for patients, improve experiences of staff and deliver clinically and financially sustainable services. Initial measures are incorporated in section 8 (page 40-42) of the DMBC.

c) That a review of community hospital bed closures be made across Devon since 2014 to establish the effectiveness of the replacement home care, including examining the role of social care.

We believe that the assurance process we are putting in place ahead of implementation will ensure that the replacement home care and availability of any social care needed will be in place to a proper level to care for people impacted by the changes. Whilst provision of social care is a matter for the Council, our evaluation of the appropriateness of the decision to close beds in a specific location, will take into account availability of social care relevant to the patient groups affected by the change.

Except for North Devon, a retrospective review across Devon since 2014 will not be reflective of the new model of care at home that has driven our latest decisions. The model in the Northern Locality is more consistent with the approach now being developed in the Eastern Locality and a better indicator of the effectiveness. The Northern Model was reported to the Committee in June 2016 and demonstrated early positive impact, including positive feedback on joint working with social care.

As the request relates to Devon we are interpreting that the Committee would also require this information for South Devon? It would be helpful to clarify this point and to understand more specifically what detailed objectives would be attached to such a review and both CCGs given an opportunity to work with you on this before the committee considers its next steps.

In summary

Before the Committee does consider its next steps, we would welcome and appreciate some further clarification of the grounds on which such a referral would be made and an opportunity to enter further dialogue with you to seek possible resolution.

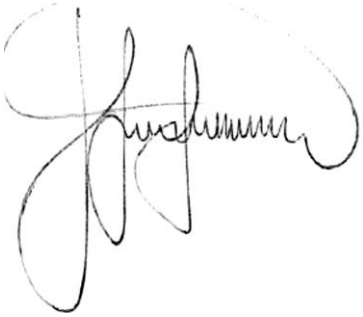
In particular, we are still unclear by the Committee's proposal to refer when, at the same meeting, the Committee endorsed a decision for full closure of four community hospitals in the South Devon area, on the basis of an almost identical, evidence-based care model and consultation process.

We are now looking at the implementation plans for the South Devon decision to ensure that plans for Eastern Devon are equally robust. If you have any particular feedback on the strengths of the South Devon implementation plans that we can adopt, please do let us know.

Finally, I do want to assure you of our intention to work closely with the Local Authority on implementation.

More broadly, we would wish to build a stronger relationship and work positively with the Committee in the future. As we appreciate that there will be local elections in May, then we would welcome a meeting after the elections so we can agree how best to achieve this.

Yours sincerely



Janet Fitzgerald
Chief Officer

Appendix 1

Responses to resolution (b) points

Scrutiny Point 1:
There is no clear explanation of what care at home will look like or work and this model has frequently been mixed up with Hospital at Home which is entirely different.

The care at home model has three components: comprehensive assessment; single point of access and rapid response. Comprehensive assessment identifies people who are at risk and assesses and plans their care when they are not in crisis. The single point of access provides a contact point for professionals to achieve a rapid response to fulfil care packages to support discharge. Rapid/urgent response, which includes rapid access to a specialist opinion, institutes a package of care for the person to help them remain at home.

These components have been described throughout the consultation and, in response to the consultation feedback, the explanation of the care model has been significantly strengthened and expanded in Appendix 1 of the Decision Making Business Case (DMBC). The CCG recognises that now the decision is made further detail will need to be provided that is specific to each affected community, prior to implementation.

The South West Clinical Senate independently reviewed the model and noted that it is in line with the policy direction set out in the Five year forward view. The wider Devon Scrutiny Spotlight Review of the model reported to the Committee in November 2016, noted that fundamentally there was support for the model of care, for better outcomes and for more intensive rehabilitation whilst there remained concerns about what this would mean in each location and whether additional services and staff will be in place.

The CCG has developed an implementation assurance process that will address this concern before inpatient beds in a location are closed. The requirement for such assurance was identified by clinicians and through the consultation and therefore is a key feature of planning safe and effective implementation.

Scrutiny point 2:

There may not be adequate care available in people's homes, given the staffing shortages in the NHS, and the significant difficulties in adult social care.

As indicated in the accompanying letter, in a given week, around 30 patients are admitted to the seven community hospitals with inpatient beds in the eastern locality. Of the four hospitals which will no longer have inpatient beds, this number of admissions is 15 to 20 per week. Whilst this was based on data for the full year 2015/16, a review of data from April to September 2016 shows these numbers remain relatively consistent. Of the 15-20 admitted per week these are largely patients requiring healthcare. Our estimate is that two-thirds or approximately 10-15 of these patients will be supported at home for example by care/nursing/therapy support according to need.

This has been borne out by recent audit of patients in community hospitals conducted by the RD&E NHS Foundation Trust on week commencing 13th March 2017. There was a consistent multi-disciplinary approach to the audit, which was conducted on each community hospital site with GPs, ward and community health and social care staff. For the total 125 patients in all 7 of the hospitals with inpatient beds at the time of the audit (this includes those admitted that week and those still in hospital from an earlier admission) this showed 64% i.e. two thirds could have been at home some without intervention and others requiring care, nursing or therapy. We are confident the new model will be able to deliver this.

In terms of the wider implications, our response to this is covered in the body of the letter relating to the assurance process we will put in place, but we would also add the following additional examples of how the system is working to address workforce and care package availability challenges:

- **Living well at home contract:** In 2016, Devon County Council and the CCG jointly established a new contract for the delivery of personal care at home. This new contract is aimed at improving quality, increasing the supply of personal care and making the best use of local provision. It is designed to benefit patients through integration of care, offer better conditions for care workers and capacity to support people at home.

- **RD&E NHS Foundation Trust contract:** In October 2016 the CCG awarded the contract for community services in Eastern Devon to RD&E NHS Foundation Trust. By integrating acute and community provision in this way the foundation is set to strengthen the resilience of community

services. Clinical leadership has already been strengthened and services will also benefit from the recognised RD&E brand as a good employer with good carer progression opportunities. This has already been demonstrated in RD&E's recent recruitment of support workers.

Further information in relation to workforce planning is covered in response to Scrutiny point 4.

Scrutiny point 3:

Hospiscare reported in its consultation response to the bed closure proposals that during 2015 managers 58 incidents reported to the CCG where the breakdown of social care packages for people at end of life had caused distress. All of these people had wanted to be cared for at home.

Hospiscare provided a helpful and comprehensive response to the consultation supporting the principle of care at home whilst making a number of suggestions to explicitly address end of life care in the model which are being taken into account. The CCG is currently conducting an end of life survey of patients and carers and the Devon Public Health end of life needs assessment is due to be updated in June 2017 and end of life care is a key workstream within the STP.

As the Scrutiny resolution notes Hospiscare response specifically made reference to incidents. Whilst specific patient details were not shared with the CCG, an overview was provided which confirmed all patients received alternative care. The point of concern was that patients could not receive their end of life choice to die at home. *Your future care* will strengthen the resilience of community health services and Hospiscare has urged the CCG to test the capacity of social care market to respond to the new model before fully implementing it.

The implementation assurance process that will take place before beds are closed does explicitly consider end of life:

'*Are the needs of people requiring palliative and terminal care identified and planned for?'*

Acute care, social care, and end of life care colleagues will be involved in this assurance process and therefore in testing readiness for implementation.

Scrutiny point 4:
There are no clear answers on how many more staff are required to make the new model of care work and that there are shortages in many health professional disciplines.

Workforce experts from across commissioners and providers have been reviewing and planning the future workforce, and specifically for Eastern Devon the provider has also been undertaking more detailed planning. Now the CCG has decided the locations for change RD&E NHS Foundation Trust can finalise these plans. The RD&E are currently working with locality teams to agree the requirements in each community to safely transfer people from bed-based models of care to care in their own home.

The CCG estimate that around 50 staff could require redeployment and these staff will have valuable skills to support our community or in-patient services. The RD&E will develop a workforce plan to support the delivery of the new model of care. A consultation process is being worked through with staff-side to ensure that we retain the valuable skills of our staff who work in the in-patent units within our community.

Around 1400 staff transferred to RD&E NHS Foundation Trust as part of the Transforming Community Services process for Eastern. Current staffing and service delivery capacity in Eastern Devon compares very favourably with the rest of Devon, and combined with RD&E's track record in relation we do not anticipate any significant issues with recruitment.

Workforce experts have also been considering the competence requirements for staff delivering the care at home model. A range of generic staff competences have already been developed and whilst many staff will have those competences the intention is to provide bespoke staff development. A new central promotion point - *Proud to Care Devon* - has been established and will soon include health as a central promotion portal for health and social care careers and jobs.

Scrutiny point 5:

Despite a significant budget deficit, there is no clear financial saving to be made. In fact once the new model of care is in place the savings may be extremely small.

The PCBC and public consultation document forecast the changes will save between £2.8m and £5.6m a year after the investment in additional community services has been made. This financial forecast was confirmed in the DMBC

(appendix 4). These savings are based on the potential to reduce 71 beds in Eastern Devon at £200-300 per bed day with 20-40% reinvestment. Most of the reinvestment will be on staff.

Whilst this saving may seem relatively modest, it forms the key to unlocking our wider vision that will transform the way we currently provide care and enables us to say with confidence that the model we are describing will be available no matter where people live in Devon. This will move us from the reliance on bed-based care to an improved, community-based service. Overall our wider programme of change is forecast to achieve net savings of between £87.5 million and £100 million a year.

Scrutiny point 6:

There is no clear plan on the future of hospital buildings that have lost their beds and are now in the ownership of NHS Property Services.

It is important to be clear that this consultation and decision relates to inpatient beds and the care at home model only. There are other services in community hospitals as set out in the local profiles provided during the consultation. No decisions on the future of buildings within the NEW Devon estate are being made as part of Your Future Care as stated in the consultation document (page 32) and the DMBC.

NHS Property Services do own the hospital buildings (excepting Tiverton Hospital) and hold the capital, leasing directly to the providers. Any vacant space in estates post any changes is the funding responsibility of the CCG. The Consultation Document clearly explains that work will take place in developing the estates strategy and confirms that members of the public will have an opportunity to comment on the estates strategy at a later date. The estates group is already in place and its role will include strategy development.

Scrutiny point 7:

The new Government direction that will come into effect next month which mean health trusts will need to prove that there is sufficient alternative provision before any beds close.

Whist these tests are to be applied before public consultation commencing from 1st April 2017, and our current understanding is they will not be applied retrospectively, it is important to be clear that the CCG's own assurance requirements for your future care are consistent with the new national approval requirements and we can therefore be confident this further test will be met.

Scrutiny point 8:

Closure of many care homes.

It is important to be clear that people are admitted to community hospitals for clinical care, rehabilitation or convalescence where nursing and medical support on an inpatient basis is required. This is different from the population of people who reside short or long term in care homes and it therefore cannot be assumed that closure of one will impact on the other.

Whilst provision of social care is a matter for the council, our evaluation of the readiness to implement the closure of beds in a specific location, will take into account availability of social care relevant to the patient groups affected by the change.

Scrutiny point 9:

Okehampton and Honiton hospitals were excluded from the consultation process.

Whilst neither of these sites featured in the four short listed sites, their suitability as options were fully evaluated along with all of the other sites in Eastern Devon within the scope of the proposals. Both Okehampton and Honiton hospitals were included in the fifteen options that passed the hurdle criteria and were then evaluated by clinicians against the agreed evaluation criteria.

Through this process, which was set out in the pre-consultation business case and consultation document, neither Okehampton nor Honiton Hospital was in the four options for consultation. These proposals and documents went through the rigour external assurance by NHS England before the CCG made the decision to consult in addition to legal advice.

Moreover, feedback on proposals for all of the sites in the scope of the consultation proposals was encouraged, and received. This included responding specifically in post consultation analysis, to feedback received about Okehampton and Honiton however further consideration did not bring them into the four shortlisted sites. It did identify the specific considerations in relation to Okehampton. This is set out in the DMBC.

Scrutiny point 10:

The temporary closure of Holsworthy Hospital which is where the patients were to be referred.

The Northern Devon Healthcare NHS Trust (NDHT) board has taken the decision to close the inpatient beds at Holsworthy Hospital temporarily under urgent measures, due to a concern about the current safe sustainability of the service. The hospital has stopped admitting inpatients and the unit will temporarily close on 31 March 2017. NDHT has noted that there are a range of issues at Holsworthy which have combined, leading to a concern about the current safe sustainability of the service

Whilst the Trust's decision on Holsworthy is not part of Your Future Care, as the Committee pointed out it will important to understand the impact on the decision to close beds at Okehampton Hospital. Whilst the issues at Holsworthy would not change the decision relating to Okehampton, its impact will be considered as part of the further work to assess more extensively the services needed in Okehampton before inpatient beds are closed as the CCG has agreed to undertake.

Scrutiny point 11:

The ongoing and significant pressure on RD & E hospital beds and difficulty with discharge.

Providing the alternative capacity is in place, as will be demonstrated through the assurance process, the changes will have no negative impact on performance at RD&E. The actual numbers of patients affected (15-20) in a week is small and distributed across the Eastern area. In addition, experience of implementing these changes in Northern Devon, has in fact helped to improve performance of secondary care services.

Delays are carefully monitored. The key reasons for delays are associated with the completion of assessments, access to NHS intermediate care or rehabilitation; and waiting for a care package at home. Current performance is however in a model with community beds. The focus of the new model of care is to achieve a more responsive community service that will further address delays.

Scrutiny point 12:

Possible doubt over the data relating to the decision to retain Sidmouth hospital beds over Seaton's hospital beds

It is worth re-emphasising that the decision to choose Sidmouth over Seaton was very finely balanced with either site being suitable to retain its beds on the basis of the outcome of the whole evaluation process. So the case for choosing one over the other is not comparatively strong. In this context, we focussed on our

specific CCG statutory duty to address population health inequalities.

The Joint Strategic Needs Assessment (JSNA) based on inequalities and taking into account critical mass and population need shows that whilst both Seaton and Sidmouth are less deprived than the Eastern average Sidmouth has a larger total population and there is also an older population profile (7.4% aged 85 and over in Sidmouth vs 6.8% in Seaton).

Since the proposals are based on a care model particularly aimed at the older population, and beds are more likely to be occupied by this age group, it was judged that retention of beds in Sidmouth would be preferable to Seaton. The Sidmouth, Tiverton and Exmouth option would also help ensure a more even geographic spread, more closely reflecting the pattern of future large-scale housing development in the county, which is heavily concentrated in the M5/A38 corridor.

Scrutiny point 13:

Staff appear to be opposed to the plans

A further review of consultation responses show that a very small proportion of staff responded directly to the consultation – less than 2% out of a total of over 1400 community staff that transferred to RD&E when it took over the services last year plus two responses from current staff side organisations and one on behalf of retired staff. The post consultation report did set out the nature of concerns raised in this context.

The views of staff are very important and changes of this nature are subject to staff engagement and consultation. RD&E are in regular contact with their staff and staff representatives and will be involving staff in the next steps in the changes as well as supporting staff in relation to the impact of change.

7th April 2017

Devon County Council

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Camilla.de.bernhardt@devon.gov.uk

Dear Ms. Fitzgerald,

I am writing to you following the consideration of the NEW Devon Clinical Commissioning Group decisions on 'Your Future Care' at the Devon County Council Health and Wellbeing Scrutiny Committee on the 7th March 2017. At this meeting the Committee expressed its continued reservations about the reduction in community hospital beds in the area covered by the Eastern Locality.

On behalf of the Committee, in line with the resolution passed, I would like to formally ask you to provide further reassurance to address the impact of each of the points outlined under resolution (b). The resolution in full is included as an addendum to this letter. I appreciate that some of these areas are not the responsibility of the Clinical Commissioning Group and I will be sending a copy of this letter to the Chief Officer for Adult Care and Health at Devon County Council for comment as appropriate.

This is also the CCG's opportunity to respond to the other parts (a) and (c) of the Scrutiny Committee's resolution.

As outlined in regulation 22 of the Local Authority (Public Health. Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 there is a statutory requirement for a response in writing within 28 days, and I look forward to hearing from you,

Yours Sincerely

Ra Westlake

Councillor Richard Westlake
Chairman of the Devon County Council Health and Wellbeing Scrutiny Committee

It was MOVED by Councillor Wright, SECONDED by Councillor Chugg and

RESOLVED

(a) that this Committee object to the decision by NEW Devon CCG to reduce the number of community hospital beds in Eastern Devon from 143 to 72 and regardless of cost no bed closures be made until it is clear there was sufficient community care provision;

(b) that, if adequate assurances are not given to the above and the issues set out below, the CCG's decision be referred to the Secretary of State for Health on the grounds that it was not in the in the interests of the health service in the area and the consultation was flawed:
:

- there is no clear explanation of what care at home will look like or work and this model has frequently been mixed up with Hospital at Home which is entirely different;
- there may not be adequate care available in people's homes, given the staffing shortages in the NHS, and the significant difficulties in adult social care;
- Hospiscare reported in its consultation response to the bed closure proposals that during 2015 managers 58 incidents reported to the CCG where the breakdown of social care packages for people at end of life had caused distress. All of these people had wanted to be cared for at home;
- there are no clear answers on how many more staff are required to make the new model of care work and that there are shortages in many health professional disciplines
- despite a significant budget deficit, there is no clear financial saving to be made. In fact once the new model of care is in place the savings may be extremely small;
- there is no clear plan on the future of hospital buildings that have lost their beds and are now in the ownership of NHS Property Services;
- the new Government direction that will come into effect next month which mean health trusts will need to prove that there is sufficient alternative provision before any beds close;
- closure of many care homes;
- Okehampton and Honiton hospitals were excluded from the consultation process;
- the temporary closure of Holsworthy Hospital which is where the patients were to be referred;
- the ongoing and significant pressure on RD & E hospital beds and difficulty with discharge;
- possible doubt over the data relating to the decision to retain Sidmouth hospital beds over Seaton's hospital beds;
- staff appear to be opposed to the plans.

(c) that a review of community hospital bed closures be made across Devon since 2014 to establish the effectiveness of the replacement home care, including examining the role of social care.

ACH/17/68
Health and Adult Care Scrutiny Committee
19 June 2017

THE BETTER CARE FUND: ALLOCATION OF ADDITIONAL SOCIAL CARE FUNDING

Report of the Head of Adult Commissioning and Health, DCC and the Director of Strategy, NEW Devon and South Devon and Torbay CCGs

Recommendations

Health and Adult Care Scrutiny

(1) Note the proposed approach to use of additional social care funding in Devon in 2017/18.

(2) Consider how it wishes to scrutinise the issues around 'Delayed Transfer of Care' and use of the new monies during 2017/18.

1. Introduction and Background

1.1 The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017.

1.2 There are specific conditions around how we use the money, and the metrics against which we will be measured, with a particular focus on reducing the numbers of delayed transfers of care. There are also conditions about how local authorities and clinical commissioning groups work together in agreeing proposals for how we use the money.

1.3 For Devon, the additional money amounts to:

2017/18	2018/19	2019/20
£15.15m	£10.15m	£5.04m

1.4 The specific conditions are as follows:

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care
- Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings)

1.5 Beyond this, we can agree locally how the fund is spent over health, care and housing schemes or services, but we need to agree how this spending will improve performance in the following four areas:

- Delayed transfers of care
- Non-elective admissions (General and Acute)
- Admissions to residential and care homes
- Effectiveness of reablement

1.6 The Care Quality Commission will hold targeted inspections informed by the use of an 'integration scorecard' built on the Better Care Fund metrics.

1.7 There are also conditions about how local authorities and clinical commissioning groups work together in establishing the fund:

- A requirement that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the local authority and Clinical Commissioning Groups.

1.8 This report recommends how this funding should be allocated, in line with national conditions, and targeting specific areas of local need. The proposals have been developed in consultation with health and social care staff and providers and are aligned to our local strategic transformation programmes of work.

2 Context

2.1 Integration

2.1.1 At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that to service users it feels like one service. People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and make more efficient use of available resources.

2.1.2 An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements. We are expected to set out how we expect to progress to further integration by 2020 in our 2017-19 Better Care Fund plan.

2.1.3 The Devon Sustainability and Transformation Plan (STP) submitted in 2016 sets out this context and case for change. All partners in the Devon health and care system share a single ambition and purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations we serve. Any allocation of funding needs to be supportive of this plan for a new model of care and help deliver these outcomes.

2.2 Population changes

2.2.1 People are living longer, with increasingly more complex care needs that require more support from health and social care services. In Devon, we are expected to experience the greatest population growth in the older age groups. 3.5% of the population in Devon is aged 85 and older, compared to 2.4% in England as a whole. An ageing population is hugely significant because older people are more likely to develop long term health needs such as diabetes, heart disease and breathing difficulties, and are more at risk of strokes, cancer and other health problems – which together means people tend to need more care and more treatment as they get older.

2.2.2 An ageing population also means increasing incidence of dementia. More than 2 out of 5 people over the age of 70 admitted in an emergency have dementia and over 45% of the hospital beds in Devon are occupied by someone with reported dementia who is medically fit to leave but has not been discharged.

2.2.3 While the average life expectancy of someone with learning disabilities is currently about 20 years less than the general population, the gap is narrowing with life expectancy of people with learning disabilities increasing by about 8 years for males and 5 years for females since the turn of the century. This presents the health and care system with the challenge of providing care

and support to this group for longer, and increasingly when parent-carers become too old to maintain such an active role in their children's lives, or pre-decease them.

2.3 **Avoidable hospital admissions**

2.3.1 Inappropriate admissions and unnecessarily long periods in hospital can be harmful, for older people in particular. The longer older people remain in hospital, the harder it is for them to regain their independence and return home, and the more likely they are to be re-admitted. NEW Devon CCG forecast that there will be 37,000 more emergency admissions to local hospitals over the next five years, an increase of more than 30% if we don't change the way we do things.

2.3.2 If we help people identify their strengths and what really matters to them and link them in with appropriate support when needed, there is potential to support people to remain independent, less reliant on care and less likely to have inappropriate admission to hospital or care homes or to need significant levels of care and support throughout their lifetime. This is the case for all people, including those with mental health conditions and learning disabilities, not just our older population. We also need to recognise that some of the support that people require can be delivered within their community and by the voluntary sector.

2.4 Winter Pressures

2.4.1 Starting in November each year, we begin to see the effect of winter pressures in the system. The term refers to how hospitals cope with increased demand but these pressures have an impact on the whole system, as increased demand at the front end affects the flow of people through the whole health and care system. However, whilst this is a seasonal spike, it now comes on top of already very high levels of activity.

2.4.2 Every urgent-care system experiences peaks of activity and 'acuity' which is often referred to as winter pressures, though these can and do occur throughout the year. These often consist of two key elements, a general increase in demand (e.g. the flu-season) often coupled with a rise in 'acuity'. Acuity is a broad term indicating the patients are more unwell and likely to take longer to get better. These two items combine to create a lack of flow through the hospital, which can cause immense pressures on delivery. It is managed within the hospital by opening extra escalation beds or cancelling planned work such as elective surgery.

2.4.3 Pressure in the system is measured using the Operational Pressures Escalation Levels (OPEL) framework which looks to collate a number of measures (e.g. A&E performance, bed availability, staff availability, discharges) to indicate a single status, OPEL 1 through to OPEL 4, to reflect the organisational situation. The measures of pressure in a complex system should not just be the acute hospitals and in Devon multiple organisations such as the ambulance service, Out-of-Hours GP service and combined Health and Social care teams are collated daily. OPEL 1 means the system is operating normally; OPEL 4 means organisations are unable to deliver comprehensive levels of care. There are specific actions, set nationally, which are required to be followed to manage the higher OPEL levels and to mitigate risk, led by the local A&E Delivery Boards.

2.4.4 Additional illnesses which are more common in winter (such as 'flu and norovirus) and colder weather can affect the most vulnerable groups in society. This results in reduced health and wellbeing in these groups, with a greater number of people dying in winter each year. These additional illnesses put further pressure on services that is not experienced during other seasons. Additionally, an increase in diarrhoea and vomiting / norovirus illnesses result in more wards being closed, reducing bed availability and the ability to move people through the system.

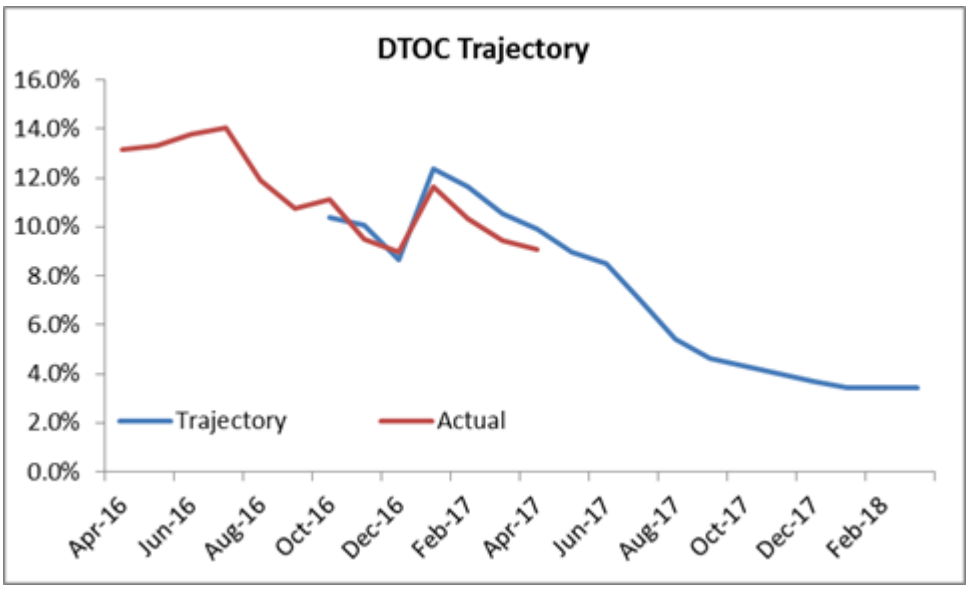
2.4.5 Many of those most affected tend to be our older and more vulnerable population who have increased care needs as much as a medical need. For example, for those over the age of 75 years there is a greater than 80% chance of needing admission from A&E, whereas for the under 30s, it is less than 20%. Once in A&E these patients will require a bed or trolley space until they are discharged from hospital. If the onward flow stops, new patients cannot be received.

2.5 Delayed Transfers of Care

2.5.1 Helping people to transfer smoothly and appropriately through the health and care system is one of the most complex tasks that the system faces. Frontline care and health staff have been dealing with this challenge for many years, but the pressure is increasing as our population ages and resources are stretched.

2.5.2 A 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care, but is unable to do so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem for the NHS as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients. Delays can occur when patients are being discharged home or to a supported care facility such as a residential or nursing home, or require further, less intensive care and are awaiting transfer to a community hospital or hospice.

2.5.3 There are several national, regional and local initiatives related to reducing avoidable hospital admissions and delayed transfers of care (DTOC) out of hospital. The Better Care Fund has always had a focus on reducing delayed transfers of care, but for 2017/18, this goes further, with a requirement to reduce DTOC to 3.5% of total bed occupancy (the RDE rate is around 12%, see figure below). DTOC is measured in both acute and community settings.



2.6 Other Challenges

2.6.1 Mental health illness is relatively common in Devon and people with complex mental health needs experience poorer health outcomes than the general population. We need to support people with mental health conditions to be able to access the support they need and to support them to live as independently in their communities as possible.

2.6.2 Our providers have difficulties with recruiting and retaining staff: many NHS staff are due to retire in the next 10 years, and local organisations already have high levels of vacancies and staff turnover in many areas.

3. High-level Principles

3.1 We propose to take a zero-tolerance approach towards delayed transfers of care, with funding decisions informed by the following principles:

- Addresses local reasons for delayed transfers of care in each locality/ system by improving flow and/or reducing demand.
- All investments need to reduce emergency hospital admissions, readmissions, DTOC, length of stay.
- Manages demand through an improved short term services offer and developing individual and community resilience
- To implement STP priorities of:
    - Single assessment process
    - Single point of access
    - Rapid response
- Informed by the national 'high impact change' guidance for reducing delayed transfers
- Strategically designed and agreed in principle but locally delivered

3.2 We propose indicative allocations to:

- Strategic county wide investments – for areas where it makes sense to design change on a county wide basis

- Locality footprints and specialist systems
    - North, East, South and West localities
    - Mental health
    - Disabilities

3.3 The high impact changes recommendations focus on getting people out of hospital, but we would also aim to do this by reducing demand through prevention and increasing sufficiency and innovation in the personal care and care homes markets, plus developing community resilience through the voluntary and community sector.

3.4 We will agree funding allocations for 2017/18 now, and plan 2018/19 and 2019/20 as part of the standard local authority and NHS financial planning arrangements.

4. Allocation of funds

4.1 Based on the over 75 populations, the allocation per locality would be as follows:

North	20%
East	49%
West	11%
South	20%

Area of spend (locality / system)	Over 75 population
Mental Health	£2m

Disability	£2m
Specialist Sub Total	**£4m**
North	£1.2m
East	£3.0m
West	£0.7m
South	£1.2m
Locality Sub Total	**£6.1m**
Community Resilience/ Prevention	£1m
TOTAL	**£11.1m**

Area of spend (county wide)	17/18	Detail
Market sufficiency Care Homes – fee rates and innovations	£2m	Increased activity putting pressure on unit rates. New joint contracting model provides vehicle for individualised approach and innovations. Any investment is likely to be recurrent.
Market Sufficiency Personal care innovations	£1m	Unit rates not an issue, but innovations on new roles, better support for staff and better retention to improve supply. Opportunity for trusted provider model. May not be recurrent.
Assistive Technology	£0.5m	Under-developed model in Devon. Agree strategy and investment one off in delivery to support prevention and new model of care.
System development: - New model of care organisational development - New workforce roles	£0.5m	Facilitation/support for practitioners to implement new model of care and design of new roles and competence to implement.
Total	£4m	

5. Development of proposals

5.1 Outline proposals were sought from staff in health and social care, using the national high impact change guidance to inform decision making.

5.2 Proposals were grouped according to high impact change area and analysed at a multi-agency care and health leadership team away day.

5.3 The resulting agreed areas of spend were as follows:

Investment area	HIC	Detail

Market sufficiency **Care homes** – fee rates and innovations Increased activity and lack of visibility of market meaning increase in unit rates. Joint contracting model being developed – likely to require recurrent funding	8 9	Investment in new fee model Care services education support team to reduce avoidable hospital admissions and drive up quality. Upskill private sector staff, tackle key reasons for avoidable admissions to hospital Trusted provider model for reviews – ensuring care meets need, also creates h&sc staff capacity
Market sufficiency **Personal care** innovations May not need recurrent funding	4 6 10	Improved short term services offer – use LWAH providers for simpler reablement cases, freeing up SCR for complex cases Trusted provider model for reviews - creates h&sc staff capacity and ensures care meets need. Also release capacity back into the market Workforce development for private sector
Short term services Links to personal care innovations and STP priorities around SPOA and rapid response	3 4 7 10	Improved short term services offer – use LWAH providers for simpler reablement cases, freeing up SCR for complex cases Assistive technology – improve and extend offer with aim to reduce / delay care packages / admissions to care homes
System development: **NMOC** organisational development Facilitation / support for practitioners to implement NMoC, design new roles	2 4 7	External expertise for systemwide end to end reviews to ensure we have a simplified and streamlined access offer, single joined-up team solutions. A process enabler to complement the NMOC / STP priorities. Staff training to include the three phase conversation model, person-centred outcomes planning Include workforce development for private and voluntary / community sector
Prevention Focus on choice Community capacity building	4 7	Social investment into voluntary and community sector – with clearly defined outcomes and metrics Links to district councils and housing offer
Adults with Disabilities – In addition to all of the schemes above, additional funding will ensure appropriate resources in the community to ensure inequalities are tackled and people with disabilities have access to opportunities within their local communities to live as independently as possible.		Investment in care management staff with a focus on autism. Supporting people with disabilities into employment. A need for more radical thinking / transformation in how we approach support for people with disabilities to ensure they are able to be independent and access services as needed.
People with mental health needs – in addition to all of the schemes above, this additional funding will ensure appropriate resources in the community to ensure inequalities are tackled and people with mental health needs have access to opportunities within their local communities to live as independently as possible.		Provide support for people with mental health needs to navigate the system, with appropriate resources in the community. Recognition that we need to improve the accessibility for our other services to include people with mental health needs. Further strategic transformations as part of our Mental Health programme of change.

6. Next Steps (including governance)

6.1 The proposals need to be signed off locally, by DCC and the two CCGs. The resulting schemes will form part of our Better Care Fund (BCF) Plan. The BCF plan is required to be formally

endorsed by the Health and Wellbeing Board before being submitted to the NHS England Better Care Fund support team for formal approval.

6.2 The Programme Delivery Executive Group (PDEG) will receive a summary of investment proposals for mutual challenge and assurance. NHS England will also be monitoring improvement in performance. Scrutiny are invited to consider how they would wish to assure themselves of progress and impact in this area.

6.3 The approved outline proposals will be further developed into clear implementation plans, including metrics to evidence success, and timelines for delivery. This will be done using the same multi-agency approach used to develop the initial proposals.

6.4 We will establish a set of system metrics to monitor the impact of the schemes at system level, and in line with the Better Care Fund national measures. These will be monitored by the local A&E Delivery Boards, with mandatory quarterly reports to NHS England. The latter will also be reported to the Health and Wellbeing Board.

7. Considerations

7.1 There are no considerations.

Tim Golby
Head of Adult Commissioning and Health, Devon County Council
Dr Sonja Manton
Director of Strategy, NEW Devon and South Devon and Torbay CCGs

Electoral Divisions: All

Cabinet Member for Adult Social Care and Health Services: Councillor Andrew Leadbetter

Chief Officer for Adult Care and Health: Jennie Stephens

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS

Contact for Enquiries:
Solveig Sansom, Senior Manager Adult Commissioning and Health
Email: solveig.sansom@devon.gov.uk
Tel No: 01392 383 000
Room: 1st Floor, The Annexe, County Hall

Background Paper	Date	File Reference
Nil		

Devon County Council

Health and Adult Care

Draft Scrutiny Work programme

The Scrutiny Work Programme details the planned activity to be undertaken over the coming months. The items on the work programme are determined by the Committee in line with the Council's Scheme of Delegation (Part 3 of the Constitution) and the Scrutiny Procedures Rules. This includes provision for the rights of County Councillors to ask for any matter to be considered by a Committee or to call-in certain decisions.

Co-ordination of the activities of Scrutiny Committees is undertaken by the Chairmen and Vice-Chairmen of Scrutiny Committees to avoid duplication of effort and to ensure that the resources of the Council are best directed to support the work of Scrutiny Committees.

Before an issue is added to the work programme Members should consider:

- Whether the issue is in the public interest
- Is there a change to National Policy?
- Does it affect people across Devon?
- Are there performance concerns?
- Is it a safety issue?
- Can scrutiny add value by looking at it?
- Is it Active?

The Work Programme will be submitted to and agreed by Scrutiny Committees at each meeting and will published on the Council's website: http://democracy.devon.gov.uk/mgPlansHome.aspx?bcr=1 as soon as possible thereafter.

An up to date version of this Plan will also be available for inspection from the Democratic Services and Scrutiny Secretariat at County Hall, Topsham Road, Exeter (Telephone: 01392 382296) between the hours of 9.30am and 4.30am on Mondays to Thursdays and 9.30am and 3.30pm on Fridays, free of charge.

The Timescales/dates are indicative of when a Scrutiny Committee will review the item it is however possible that they may need to be rescheduled and new items added as new circumstances come to light. Please ensure therefore that you refer to the most up to date Plan.
Copies of Agenda and Reports of Scrutiny Committees of the County Council referred to in this Forward Plan area also available on the Councils Website at (http://www.devon.gov.uk/dcc/committee/mingifs.html)

Date	**Standing Overview Group/s**	**Masterclass**	**Committee**
	Purpose: a detailed informal discussion forum to deepen member's understanding of specific topics. Headline actions back to committee **Frequency:** Meetings held in between the committee cycle	**Purpose:** An information sharing session where issues can be presented informally to members to raise awareness and increase knowledge– open to all members of the Council. No formal minutes or notes taken **Frequency**: The morning before each Committee meeting	**Purpose**: A formal public meeting where active items are discussed and actions taken. Covered by the constitution. **Frequency:** Approx. 5 times a year
19th June		- Health and Care system - One small step - Legislation governing health scrutiny and ASC	- Additional Monies - Winter pressures - Your Future Care for resolution
July/Aug?	- Performance possibly incl. quality accounts - STP key objectives and new models of care - Mental Health		
21st Sept		- ICE - Locality based developments - Services to older people	- Workforce and agency spend - STP Acute services review - Performance - Devon Safeguarding Adults Board
Oct	- Public health – health inequalities/communities/prevention - Integration health and social care		
21st Nov		- Delayed transfer of care - Budget - HealthWatch	- Mental health - ICE - Public Health Grant

Date	**Standing Overview Group/s**	**Masterclass**	**Committee**
			- Adult Social Care Annual Report and outcomes framework
Dec	- Safeguarding and Quality - Annual adult social care report follow up - GP work force issues		
25th Jan 2018		- CQC - Peer review findings? - Disabilities transformation plan	- Budget
Feb 2018	Anticipated Green Paper on Social Care		
22nd March 2018		- Transition - Short term offer	- Peer review findings? - Disabilities transformation plan
April	Annual Performance returns Quality Accounts		

Task Groups/Spotlight Reviews

Start date	Title/description	Chair	Anticipated end date
	TBD		