Devon County Council

Phil Norrey
Chief Executive

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

County Hall
Topsham Road
Exeter
Devon
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(See below)

Your ref :
Our ref :
Date : 17 July 2017
Please ask for : Gerry Rufolo 01392 382299
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HEALTH AND ADULT CARE SCRUTINY COMMITTEE

Tuesday, 25th July, 2017

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

P NORREY
Chief Executive

A G E N D A

PART 1 - OPEN COMMITTEE

1 Apologies

2 Items Requiring Urgent Attention

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

3 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

4 Your Future Care: North, East, West Devon Clinical Commissioning Group (NEW Devon CCG) and Royal Devon and Exeter Foundation Trust: Eastern Locality: New Model of Care

(a) Background Evidence

Report of the County Solicitor (CS/17/23), attached (Pages 1 - 9)

(b) NEW Devon CCG and Royal Devon & Exeter Foundation Trust: Response

Report of NEW Devon CCG and Royal Devon & Exeter Foundation Trust, attached (Pages 11 - 20)

(c) Implementation Assurance Panel: Meetings held on 12 July and 19 July 2017 and Hospital and Community Visits

Chairman and Members in attendance to report

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

Nil

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Membership

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

Devon District Councils

Councillor P Diviani

Declaration of Interests

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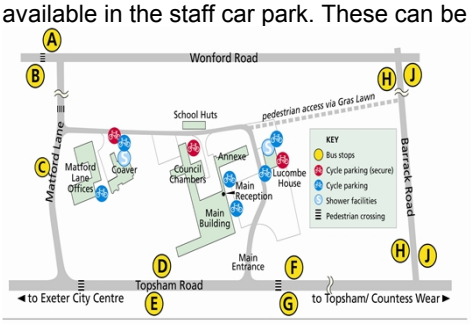

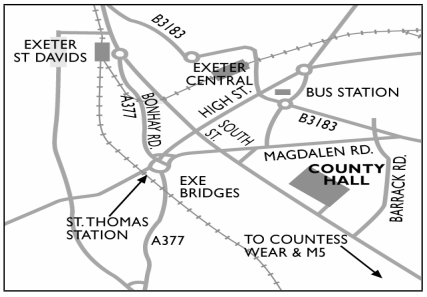

NB (A) (J) **Denotes bus stops**

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Health and Adult Care Scrutiny Committee **CS/17/23**

'Your Future Care' scrutiny information to support Committee's deliberations

25 July 2017

Purpose: This paper has been written to enable the Committee to evaluate the extent to which the requirements of a referral to the Secretary of State for Health have been met. This issue has been raised by the Committee in response to decisions taken by NEW Devon CCG relating to closing community hospital beds in the Eastern Locality. This paper provides an overview of the answers that the Clinical Commissioning Group has provided to the questions that Scrutiny has asked. It is for the Scrutiny Committee to determine if it is satisfied and therefore there is no conclusive position presented.

This paper does not represent the full work that would be needed if the Committee decides to refer, but aims to give a summary for the purpose of supporting the Committee to make a decision based on evidence. Members are asked to take account of the questions in this document in their ongoing consideration of the issue.

The format of the paper is written to address in turn the nine points that are required by the scrutiny guidance for a referral.

1. An explanation of the proposal to which the report relates.

This consideration relates to the consultation and decision taken by NEW Devon Clinical Commissioning Group with regard to the proposals entitled 'Your Future Care'. The consultation ran from 7th October 2016 for a period of 13 weeks. The stated intention of this work has been to address sustainability concerns to meet the changing needs of the population, to improve outcomes for patients and ensure the financial sustainability of community services.

The specific consultation has been on the reduction in community hospital inpatient beds in the Eastern Locality of Devon from 143 to 72. There are currently seven community hospitals in Eastern Devon with inpatient beds, under the proposals this number would move to three. The consultation gave four options to choose from with combinations of Tiverton, Sidmouth, Seaton, Exmouth and Exeter.

2. An explanation of the reasons for making the referral.

Members of the Committee need to be clear on the outcome that they desire. Initial canvassing has led to two possible grounds for referral:

a/ referral based upon inadequate consultation- (could result in the Secretary of State requesting the Clinical Commissioning Group to repeat the consultation process).

b/ referral based upon the Committee believing that the proposals are not in the interests of the health service in its area (could result in a full review by the IRP).

3. Evidence in support of these reasons.

a/ Referral based upon inadequate consultation
With regard to Consultation the principles are here:
https://www.gov.uk/government/publications/consultation-principles-guidance
There is no evidence to suggest that these eleven principles have not been met.

b/ The proposals are not in the interests of the health service in the area.
The committee has received written representations from 21 members of the public as well as a letter from the District Council Health Scrutiny Committee requesting that this issue is looked at and sent to the Secretary of State. The points raised in these submissions and also by members of the Committee are explored further in this report.

4. Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.

There has been the suggestion that there is inadequate consultation because the options for retaining the beds at Honiton and or Okehampton were not choices in the consultation paper.

The answer that scrutiny has received is as follows:
'Throughout the consultation period the Clinical Commissioning Group *attended over 70 events and public meetings. In total more than 2000 people attended these events and discussed the proposals. We also received 1552 responses to the survey, plus more than 650 letters and emails in total. A full post-consultation report can be found on the* Clinical Commissioning Group *website. An independent observation report has also been provided by Healthwatch Devon and can also be found on the* Clinical Commissioning Group *website.' Stakeholder briefing 1st March 2017.*

'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 rigourous external assurance by NHS England before the Clinical Commissioning Group *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 Decision Making Business Case'

Due to the fact that the Clinical Commissioning Group received consultation responses in the free text boxes to consider Honiton and Okehampton hospitals it is difficult to assert that members of the public could not voice their opinion on these options, although they were not specifically in the four options.
The committee may wish to ask the Clinical Commissioning Group how the results of the consultation influenced the final decision.

5. **Where the proposal is referred because there was no consultation for reasons relating to safety or welfare of patients or staff, reasons why the health scrutiny body is not satisfied that the reasons given for lack of consultation are adequate.**

N/A The consultation period ran for 13 weeks from 7th October 2016.

6. **Where the health scrutiny committee believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.**

Evidence considered:

Date	Document	organization
21 Sept 2016	Devon Pre-Consultation Business Case https://www.newdevonClinical Commissioning Group.nhs.uk/your-future-care/publications-and-evidence-sources-102088	The Devon Success Regime
27th Sept 2016	Stage Two Clinical Review Report NEW Devon Clinical Commissioning Group's Proposals to Changes to Community Beds http://www.swsenate.org.uk/wp/wp-content/uploads/2013/12/Clinical-Review-Report-NEW-Devon-CLINICAL COMMISSIONING GROUP-proposals-re-community-beds-Final-...-3.pdf	Clinical Senate
7th Oct – 6thJan	Consultation document https://www.newdevonClinical Commissioning Group.nhs.uk/your-future-care/consultation-document-102084 consultation response form http://democracy.devon.gov.uk/documents/s5116/Appendix%201%20b%20Your%20future.pdf	NEW Devon CLINICAL COMMISSIONING GROUP
23 Feb 2017	Post Consultation report https://www.newdevonClinical Commissioning Group.nhs.uk/your-future-care/post-consultation-report-102200	NEW Devon CLINICAL COMMISSIONING GROUP
2nd March	Decision Making business case https://www.newdevonClinical Commissioning Group.nhs.uk/your-future-care/decision-making-business-case-102203	NEW Devon CLINICAL COMMISSIONING GROUP
7th March	Health and Wellbeing Scrutiny Committee meeting report http://democracy.devon.gov.uk/documents/g1981/Public%20reports%20pack%2007th-Mar-2017%2014.00%20Health%20and%20Wellbeing%20Scrutiny%20Committee.pdf?T=10	NEW Devon CLINICAL COMMISSIONING GROUP
7th April	Evidence presented by Clinical Commissioning Group in response to points raised at committee. Letter and Appendix http://democracy.devon.gov.uk/documents/s7948/20170407%20JF%20letter%20to%20RW%20Chair%20HWSC%20DCC%20Final.pdf	NEW Devon CLINICAL COMMISSIONING GROUP

	http://democracy.devon.gov.uk/documents/s7949/20170407%20Appendix%20to%20HWSC.pdf	
6th June	Letter to Cllr Sara Randall-Johnson http://democracy.devon.gov.uk/documents/s7946/060617.pdf	NEW Devon CLINICAL COMMISSIONING GROUP
19th June	Health and Adult Care Committee report http://democracy.devon.gov.uk/documents/s7945/Your%20future%20care%20NEW%20CLINICAL COMMISSIONING GROUP%20l.pdf	NEW Devon Clinical Commissioning Group

The Committee has considered the documents in the table above. However there are a number of pertinent questions that need particular attention. The next section of this paper summarises the answers from this documentation that the Committee has received.

Detail of outstanding questions:

- **Why Sidmouth over Seaton?**

The Committee was informed that at the point of going to consultation the preferred option was Option A – which included Seaton. The Clinical Commissioning Group board decision was then option B – which excluded Seaton in favour of Sidmouth.

Concerns have been raised over what information including population demographics and geographic boundaries were considered to make this decision.

Committee has received evidence to the extent:
'…the decision to choose Sidmouth over Seaton was very finely balanced. In this context, we focussed on our specific Clinical Commissioning Group *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.'* Letter from Clinical Commissioning Group to Cllr Richard Westlake 7th April 2017
In summary:

- Sidmouth has a larger population, and a larger percentage of this population over 85 (7.4% aged 85 and over in Sidmouth vs 6.8% in Seaton)
- Retaining beds in Sidmouth, Tiverton and Exmouth wasseen to ensure a more even geographic spread in line with future housing developments.

Questions over this part of the decision do not call into question the model of care, but the decision making criteria.
The Committee is likely to need clarity over where the geographical boundaries are drawn for this decision and which population areas were taken into account.
The Committee may also wish to understand how consultation respondent's preferences were considered in the final decision.

Implementation

- **Staff and Workforce**

The Committee understands that some staff responded to the general consultation, but that there has also been a concerted engagement programme from the provider. The Committee has raised concerns over change of working conditions and whether staff will want to work

in the new way offered, whether any staff will be made redundant and generally what the views of staff undergoing this change were.

The Committee have been informed of the following regarding workforce:

- An estimated 50 staff will need to be redeployed. This could be into the community or into other sites.
- The RD&E is leading the workforce plan
- The RD&E have a strong track record on staff recruitment
- 'Proud to Care Devon' – 'will soon include health as a central promotion portal for health and social care careers and jobs'

The Committee has to date received limited evidence of staff views and outcomes on the proposals largely due to the nature of ongoing consultation. The Committee should expect evidence to demonstrate that staff will not be adversely affected by the proposals and can meet the Clinical Commissioning Group's assertion of having improved experiences.

- **Future of Buildings**

The Committee accepts that the plans for the buildings have not been part of the strategic planning for the current proposals, but Members want them to remain centres of care in the community. There is an enduring concern that removing the beds from some hospitals might leave them more vulnerable to closure at a later date in light of rent charges from NHS Property Services.

The Committee has been informed:
'Although ownership of these facilities is with NHS Property Services, out 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.' Letter to Cllr Westlake

'Whilst NHS Property Services owns and runs many facilities, declaration of a facility as surplus to requirements is the responsibility of the Clinical Commissioning Group*. 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* Clinical Commissioning Group*. 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'.*

The Committee could reasonably expect an answer on future plans to give reassurance to communities. This may include plans to develop services in the locality to ensure local hubs develop and are sustainable.

- **Keeping the status quo**

Members of the public and Councillors have asked if the current situation can remain unchanged.

In the decision making business case the Clinical Commissioning Group outlines the need to make changes. Evidence was informed by the 'transforming community Services' work that has been carried out by the Clinical Commissioning Group and was published in October 2014. This was further developed by the Success Regime, essentially that: 'it is *becoming*

increasingly difficult to make sure local people have access to consistently high quality care that is affordable and sustainable'.

The argument for change is put by the Clinical Commissioning Group:

'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' letter to former chair of health scrutiny 7th April.

The Committee can ask for the status quo to be continued, however any submission would need to demonstrate the same anticipated outcomes as the proposed changes – namely strong clinical outcomes and ongoing financial sustainability. It is unclear how this could be provided.

- **Finances**

The Committee has questioned the variable figures accounted for cost savings against reinvestment.

The Committee has been informed:
'Pre Consultation Business Case 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' – 'based on potential to reduce 71 beds in Eastern Devon at £200-300 per bed per day with 20-40% (largely staff based) reinvestment'

'implementing the new model of care is forecast to deliver gross savings of £122.0-124.3m, mainly from reductions in length of stay in beds in acute and community hospitals, a reduction in emergency activity, a reduction in continuing care and promotion of excellent care initiatives in social care' Pre-consultation Business Case

The Committee may require a breakdown of projected cost savings against expenditure.
Scrutiny should also be asking questions about financial information when it reviews other changes as part of the Sustainability and Transformation Plan.

- **Implementation Assurance Panel**

The Committee have asked questions about the conditions set by the Clinical Commissioning Group before implementation begins.

The Committee has been advised:
'The Clinical Commissioning Group 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' Taken from letter to Cllr Randall-Johnson

The Committee has been invited to observe the implementation assurance panel.

The Committee should hear from the members who have observed the Implementation Assurance Panel to ascertain if they are satisfied with the thoroughness of the process.

7. An explanation of any steps that the health scrutiny committee has taken to try to reach agreement with the relevant NHS body or health service provider.

The timeline of this issue, including consideration by scrutiny is summarised in the table below

Date	Activity	Event	Relevant documentation attached
7th Oct -	Consultation period 13 weeks The consultation set out four options for the location of a reduced number of inpatient beds in community hospitals in Eastern Devon.		
8th Nov 2016	'Your Future Care' Consultation. 'RESOLVED that NEW Clinical Commissioning Group be requested to liaise with local Councillors in order to assist with the development of additional options in response to the on-going consultation 'Your Future Care' for communities such as, for example, Okehampton and Honiton'	Health and Wellbeing Committee	http://democracy.devon.gov.uk/ieListDocuments.aspx?CId=130&MId=245&Ver=4
Jan 2017	'Your Future Care' consultation and Next Steps Report from Clinical Commissioning Group outlined the extensive consultation processes and responses and a detailed summary and the next steps 'RESOLVED that the NEW Devon Clinical Commissioning Group be requested to provide a further update to this Committee's March meeting.'	Health and Wellbeing Committee	http://www.devoncc.ukcouncil.net/site/mg_bounce.php?mg_a_id=4668&mg_m_id=2292
2nd March 2017	Decision: - a reduction of community hospital beds from 143 to 72 in the Eastern locality - Tiverton & District Hospital to be a fixed point providing an inpatient unit with 32 beds - Exmouth Community Hospital as a 16-bedded hospital - Sidmouth Community Hospital as a 24-bedded hospital - in light of the rurality and associated factors, to commission further work to assess more extensively the services needed in the Okehampton area.	CLINICAL COMMISSIONING GROUP Board Meeting	

7th March 2017	Meeting resolution: (a) that this Committee object to the decision by NEW Devon Clinical Commissioning Group 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 Clinical Commissioning Group'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: (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.	Health and Wellbeing Committee	http://democracy.devon.gov.uk/mgAi.aspx?ID=5550
9th March	Letter from Chairman of H&WB scrutiny to NEW Devon Clinical Commissioning Group Requesting the evidence to answer the 14 points as outlined at committee.		
7th April	Janet Fitzgerald, Chief Officer – Health and Wellbeing Scrutiny Committee. Letter and Appendix addressing the points.		
24th April	Cllr Westlake – Janet Fitzgerald, asking for additional information on the points not addressed.		
6th June	Letter Janet Fitzgerald – New Chair Cllr Sara Randall-Johnson addressing these points		
19th June	Report to committee – more information Committee resolved: that consideration of a referral to the Secretary of State be deferred pending a special meeting of this Scrutiny Committee (by end of July) to consider further information and evidence from the NEW Devon Clinical Commissioning Group in relation to the Your Future Care decision	Health and Adult Care Scrutiny Committee	http://democracy.devon.gov.uk/ieListDocuments.aspx?CId=429&MId=2581&Ver=4
25th June	Committee – outcome TBD		

8. Evidence that the health scrutiny committee has complied with the requirements which apply where a recommendation has been made.

This is a subjective point and is covered in the discussion and options under points above.

9. Evidence that the health scrutiny committee has complied with the requirements which apply where a recommendation has not

been made, or where no comments have been provided on the proposal.

NA at this time, there are still outstanding questions.

Jan Shadbolt
County Solicitor

Health and Adult Care Scrutiny Committee: 25 July 2017

Your Future Care

Report of the Director of Strategy (CCGs), Chief Operating Officer (CCG) and Deputy Chief Executive/Chief Nurse (Royal Devon and Exeter NHS Foundation Trust).

Purpose

The purpose of the following paper is to briefly outline the model of care in the Eastern Locality area and explain the implementation process followed.

Recommendations

That the Health and Adult Care Scrutiny Committee

(1) Notes the purpose and approach to change in the model of care
(2) Considers how it wishes to continue to scrutinise issues around 'Your Future Care'

Executive summary

The NHS in Devon is moving towards a model of care that focuses on community and home-based services – similar to that offered by Devon County Council.

The approach complements many of the services offered by Devon County Council's adult social services, such as social care, which work alongside the NHS multidisciplinary teams (MDTs) in communities throughout Devon. It brings 57 additional nursing, therapy, care workers and pharmacists to community services in the Eastern Locality.

Once patients are well enough to leave an acute setting, community services and staff available in their local community will ensure that they can return home safely and be as independent as they possibly can. Similarly when admission to hospital can be avoided, people will be supported earlier and receive care at home where necessary.

This is very different from the existing model of bed-based care which means many people who are well enough to return home with additional support are forced to remain in hospital - due to the lack of available services in the community. Prolonged and unnecessary stays in hospital have been proven to be bad for patients.

On average 875 inpatients a year will be affected by the change of model. This equates to average of about 3 people per week per site (see 3.2 over for detail).

The Your Future Care process will release resources through closing community inpatient beds, almost half of which will be re-invested in community services in the Eastern Locality, and will in turn reduce the need for bed-based care in community hospitals.

Under a changed model of care, there will be a tailored care plan for each and every patient, which addresses their individual needs and helps them to get back on their feet as quickly as possible.

Evidence from where the model is in place already shows that patients are healthy and independent enough to be discharged after an average of nine days, while the average length of stay in hospital for similar patients is 29 days. This is important because independent analysis by the National Audit Office shows that older people can lose as much as 5 per cent of their muscle strength for every additional day they spend unnecessarily in a hospital bed.

The same report shows that an average 67-year-old admitted to hospital in reasonably good health loses 14 per cent of their hip and muscle strength after just ten days. They lose 12 per cent of their lung capacity and the overall decline in their mobility and fitness is equivalent to losing ten years of life.

A significant amount of implementation planning has already been undertaken following engagement with the workforce, stakeholders and local communities.

1. The model of care

1.1 Over a number of years there has been an emphasis on changing the model of care, particularly for older people who are frail. The focus of this change is to personalise care, prevent a health crisis where possible through pro-active approaches and, where care and support are needed, to provide this at home where it is safe to do so.

1.2 To achieve this clinical advice and policy direction are clear that in the first instance resources and attention need to shift from the present over-reliance on hospital beds to create quality out of hospital services that meet people's needs, proactively manage risk and promote independence, health and wellbeing. This shift in emphasis is at the centre of the Your Future Care plans.

1.3 As previously reported to the Committee, three interventions have been identified by clinicians and the foundation of out of hospital care:

- Comprehensive assessment: This identifies people who are frail or becoming frail, and therefore are at risk of being admitted to hospital. It puts a care plan in place for them, owned by the individual.
- Single point of access: One phone number, which is now in place through a service known as Community Connect, will make getting additional support when it is needed as easy as possible. It will be connected to an Urgent Response service.
- Urgent Response (Care at Home): This service will help people to remain at home with support, rather than being admitted to hospital. Where hospital admission is unavoidable, it will provide the additional support at home that makes it safer to leave hospital.

1.4 For patients spending longer than necessary in hospital there is evidence that this can have a negative impact on their health and wellbeing. Independent analysis (published on 26th May 2016) by the National Audit Office shows that older people can lose as much as 5 per cent of their muscle strength for every additional day they spend unnecessarily in a hospital bed. Locally there is a clinical consensus that supports the move away from long term bed based care for patients.

1.5 The same report shows that an average 67-year-old admitted to hospital in reasonably good health loses 14 per cent of their hip and muscle strength after just ten days. They lose 12 per cent of their lung capacity and the overall decline in their mobility and fitness is equivalent to losing ten years of life. The current average length of stay in a community hospital bed is 29 days - and many patients will have already spent time in acute hospital bed before this.

1.6 Your future care in Eastern Devon reduces inpatient beds in Community Hospitals by 71, from 143 to 72. By directing this 'bed-based' investment towards home-based and community care when the patient is well enough to be out of hospital, the support and workforce will be better placed to help people remain at home or return to their homes, and the right care to be as independent as possible.

1.7 Those remaining beds in community hospitals will be used for intensive rehabilitation, shortening length of stay and ensuring patients are returned to independence more quickly.

2. What this means for people

2.1 First and foremost, the support will be available outside of hospital to enable people to receive consistent and quality services at home. These span from identifying their needs earlier, before a health crises, to a range of skills including nursing, therapy and other support to care at home when this is needed. These out of hospital services will be available 7 days a week, 365 days a year.

2.2 An illustration of the model in action is provided for John, an example created from what will be the typical patient experience in East Devon.

Helping John to get back on his feet and into his own home, after an illness that led to him being admitted to an acute hospital.

Day 2 – The Therapy Assistant arrives to complete a functional (or basic) wash and dress assessment, and this assistant will continue to work with John to help him with his goals. Enabling care will be provided for John twice daily and the therapy assistant provides John with his third care visit. John is now progressing well enough for the night sitter to be stepped down.

Day 3 – John is visited by the Therapy Assistant who continues to support him in progressing his mobility and function. John receives enabling care twice a day.

Day 4 – The Occupational Therapist completes John's review, and confirms that John is now progressing well enough that enabling care will now take place only once a day - in the evening in addition to support from the Therapy Assistant.

Day 5 – The Therapy Assistant calls John at home and agrees to step down enabling care and review John's goals and progress at day 7.

Day 6 – The Therapy Assistant visits John to measure his progress and abilities to be independent.

Day 7 – The Therapy Assistant completes another visit with John and agrees that he has progressed well, and is now safely able to be independent in his home.

It is agreed with John that on-going befriending support from Neighbourhood Friends would be helpful.

The Therapy Assistant makes the referral to Neighbourhood Friends and in agreement with John discharges him.

2.3 An illustration of the challenges faced by the patient with the existing model of bed-based care.

Challenges faced by John with the existing model of bed-based care.

John is placed on a busy ward, and is well treated by the caring staff.

There are not enough services in the community to support John in his own home, so the doctors choose to send John to a community hospital which is approximately 10 minutes' drive from John's house.

John is given therapy three times a week, but begins to lose independence as drinks and food are generally brought direct to his bed.

Being confined to a ward setting John means he is less active and less independent than he normally would be at home.

John reads books and newspapers and chats to the other patients, but the lack of stimulation and independent activity is making his progress slow.

After 28 days John is pleased to return home close to his friends and neighbours, but his physical and mental condition have deteriorated, making him less safe in his own home, and more likely to have a fall or accident resulting in another prolonged spell in hospital.

2.4 Already steps have been taken to improve services - with Community Connect being established throughout the Eastern Locality **on 24th March 2017** and a 'discharge to assess' pilot in Exeter to avoid people staying in hospital longer than they need to but ensuring an assessment of what is needed at home.

2.5 The following table provides a comparison between the existing and new model:

Community Hospital	Out of Hospital Model
Average length of stay = 29 days	Patient independent and healthy enough to be discharged after an average of 9 days
MDT available on ward	Wrap around MDT support available
Average Therapy input 3 times weekly	Therapy input can be daily as required
Busy ward based setting	Familiar and quiet environment

Aim to be flexible on visiting times	Personal space and flexibility on visitors
Assessing and re-assessing people's function using ward kitchens, wide stairs	Give people time to settle home and assess them in their own environment; "my bed, chair and kitchen taps"
Mainly GP led	Patch Geriatrician support available
11% re-admission rate	Appropriate readmission rate of 7%

3. How change will look in practice

3.1 A key feature of implementation is the level of additional investment into the community health and social care teams, with additional nursing, therapy, care workers and pharmacists in each locality cluster. There are consultant geriatricians to support people in their own homes supporting GPs to provide the very best medical care where this is required.

3.2 Further recent modelling of impact of the changes and workforce allocations are set out below. This represents 57.23 additional whole time equivalent staff.

Community	Modelled impact	Workforce
Crediton, Moretonhampstead and Okehampton	2.19 patients per week	8.91 wte
Exeter	5.22 patients per week	13.81 wte
Woodbury, Exmouth, Budleigh	1.96 patients per week	7.93 wte
Tiverton and Cullompton	3.12 patients per week	11.23 wte
Honiton and Ottery St Mary	1.98 patients per week	5.65 wte
Seaton, Axminster, Sidmouth	2.28 patients per week	9.70 wte

3.3 Over the course of a year, recent modelling shows that the total number of people affected by the change to inpatient services is 875 people which equates to a very low number of people in each locality cluster as shown in the table above.

3.4 A further audit conducted by RD&E showed that of all 125 people in community hospital beds in seven Eastern hospitals during a week in March 2017, only 17% required community bed based care, 53% could go home with support and 11% did not require further support.

3.5 Closing the inpatient beds will both save money and increase staffing and support for people in the community. Through detailed work on the funding by RD&E, whilst higher than the original 20-40% re-investment estimates, it still saves over 50% of the resource spent on beds and invests the remainder in the community to bring about enhanced out of hospital services.

4 Ensuring readiness for implementation

4.1 A key message from the public and clinicians alike has been the importance of safe and quality implementation. A series of 30 gateway questions were developed and a panel involving GP, consultant geriatrician, lay community representatives (members of the public), public health, social care and commissioning input was been established to check readiness implementation.

4.2 The work of this panel is in addition to the responsibility of Royal Devon and Exeter NHS Foundation Trust to deliver safe and quality services and is designed to provide added assurance and confidence in the out of hospital model of care as well as the in-hospital care that will take place in fewer overall beds. Members of the Committee have observed one panel meeting and the invitation is extended to future meetings.

4.3 Chaired by a GP the panel has met and received and reviewed presentations and evidence from RD&E NHS Foundation Trust spanning the following parameters and questions:

Parameter	Question
The model of care	• Does the new model of care align with the overriding ambition to promote independence? • Is there clinical and operational consensus in place on the functions of the model and configuration of community health and care teams incorporating primary care, personal care providers and the voluntary care sector? • Is there a short term offer that promotes independence and community resilience? • Is there a method for identifying people at highest risk based on risk stratification tool? • Are the needs of people requiring palliative and terminal care identified and planned for? • Are the needs of people with dementia identified and planned for? • Is support to care homes and personal care providers built into the community services specification? • Is support for carers enhanced through community sector development support in each community? • Has the health and care role of each part of the

	system been described? • Have key performance indicators been identified, and is performance being tracked now to support post-implementation evaluation, including impact on primary care and social care?
Workforce	• Is there a clear understanding of the capacity and gaps in the locality and a baseline agreed for current levels and required levels to meet the expected outputs of the changed model of care? • Is there a clear understanding of and plan for any changes required in ways of working: Thinking, behaviours, risk tolerance, promotion of independence, personal goal orientation. • Have the training needs of people undertaking new roles been identified, including ensuring they are able to meet the needs of patients with dementia? • Is there detailed knowledge with regards to investment, WTE and skill mix across the locality and a plan for achieving this? • Are system-wide staff recruitment and retention issues adequately addressed with a comprehensive plan, and where there are known or expected difficulties have innovative staffing models been explored?
Governance communication and engagement	• Is there a robust operational managerial model and leadership to support the implementation? • Has council member engagement and appropriate scrutiny taken place? • Is there an oversight and steering group in place and the process for readiness assessment agreed? • Have providers, commissioners and service users and carers or their representative groups such as Healthwatch agreed a set of key outcome measures and described how these will be recorded and monitored? • Is there a shared dashboard which describes outcomes, activity and productivity measures

	and provides evaluation measures?
Implementation	• Is there a clinical and operational consensus on the roles of each sector during the implementation phase including acute care, community health and care teams, mental health, primary care, social care, the voluntary care sector and independent sector care providers? • Is there an implementation plan at individual patient level describing their new pathway, mapping affected patients into new services? • Are the operational conditions necessary for safe implementation met? • Have the risks of not implementing the change at this point been described and balanced against any residual risk of doing so?
Post implementation	• Is there a description of the outcomes for individuals, their carers and communities? • Are the mechanisms for engagement with staff, users of services and carers in place and any findings being addressed appropriately? • Is there a process in place for immediate post-implementation tracking of service performance, including financial impact to all organisations? • Is longer-term performance and impact being tracked for comparison against pre-implementation performance? • Has user experience been captured as part of the process, and have findings been addressed and recorded to inform the planning of future changes? • Are there unintended consequences or impacts (e.g. on primary care or social care) which need to be addressed before any further change occurs? • Is there a clear communication plan for providers and the public describing the new system and retaining their involvement in community development?

4.4 In addition the panel has had feedback from a working group of medical, nursing, therapy and pharmacy leads and operational managers of the services (Clinical/professional reference group) and the GP chair of this group has confirmed the group's support indicating they were now very close to being satisfied that it is safe to close the community hospital inpatient beds. The panel is preparing its final recommendations, including the updated Quality and Equality Impact Assessment and the outcome and evaluation metrics to be used.

4.5 Royal Devon and Exeter NHS Foundation Trust has completed consultation with staff and whilst change of this nature brings concern and uncertainty it also brings opportunities and many staff are now getting ready to take on new roles and training and support will be offered as required. There is further recruitment to be completed and this is underway.

5. Post implementation

5.1 Following implementation of the changes the model will continue to be monitored and evaluated to ensure it delivers the benefits of improved experiences and outcomes for patients; improved experiences for staff and clinical and financial sustainability of services.

5.2 The clinical professional reference group will continue to work on service development and the assurance panel will review and report at intervals on the outcomes and metrics and scrutiny member continued observation with and future engagement in these processes is invited.

6. More information

Technical supporting information has already been provided to the Committee and can be made available again on request.