Health and Wellbeing Scrutiny Committee

Sustainability and Transformation Plan Model of Care Joint Spotlight Review

November 2016

1. Introduction

1.1 The Health and Wellbeing Scrutiny Committee and the People's Scrutiny Committee from Devon County Council met with the Torbay Community Services Review Panel and the Plymouth Wellbeing Scrutiny Committee on the 5th October for a spotlight review. The review forms part of the on-going work to understand and scrutinise the activities that make up the Sustainability and Transformation Plan (STP) and the changes in localities that follow this plan.

1.2 The STP is a nationally required plan to set the future direction for local health services. Across the Country there will be 44, one covering each area as determined by Central Government. In Devon this area covers the North, East and West Clinical Commissioning Group and the South Devon and Torbay Clinical Commissioning Group. It also spans the areas covered by Devon County Council, Torbay Council and Plymouth City Council. To take this into consideration the spotlight review had all three authorities and both the CCGs present.

1.3 This spotlight review was set up to enable greater understanding of principles that underpin the changes that are anticipated. The focus of the session was to further explore the rationale for change and to openly explore what the positive and negative aspects of change might be. The stated objectives of the meeting were to:

- Members of all three authorities to clearly establish what the new model of care is.
- Members to ascertain what will be the impact of changes to the person receiving care.
- Scrutiny to undertake a 'SWOT' analysis of the model of care to be used as required in each authority.

1.4 This spotlight review does not constitute a joint committee. It is the intention that a short report will be produced following the spotlight review which can then be considered by each authority's relevant Scrutiny Committee. This investigation has not undertaken a detailed review of the consultation process or reviewed changes from the Success Regime, CCGs or STP including looking at specific hospitals. This is anticipated to be considered on a local level.

1.5 The format of this one-off meeting was designed to create the conditions for a more generative conversation. Balancing the need for input with the need for questions and exploration. The first part of the session was mainly input from Angela Pedder and clinicians on what the new model of care will mean for individuals. Members across the three committees listened to understand the objectives and potential of the new model of care. The second part of the meeting involved table discussions with everyone present to conduct a SWOT analysis where members were able to voice the positives and negatives that they had heard about the system. This part of the session in turn also involved listening, so clinicians could hear first-hand what the concerns of the members of pubic were. The final part of the session involved a feedback summary on the strengths, weaknesses, opportunities and threats that were discussed. The session concluded with a question and answer session to enable any outstanding questions or points to be discussed.

2. What is the 'new model of care' and the evidence base?

2.1 The model of care builds upon many aspects of service planning and delivery that have been developed over time. The 'Success Regime' was invoked to work with the North, East, West (NEW) Devon CCG, along with two other areas in the Country, to change the trajectory of spending. Part of this support requires a credible plan to match demand with allocated resources. This does not cover the area of South Devon and Torbay CCG but crucially the STP does. This means that preparatory work for the NEW Devon CCG under the auspices of the Success Regime will be included in the final plan which will also include South Devon and Torbay. The STP builds on the work of the CCGs and case for change for each area; it sets out how local services will evolve and become clinically and financially sustainable in the next 5 years.

2.2 The STP will provide a framework. It details the principles and strategy which will then be applied across Devon. This has been developed over the summer with more than 80 clinicians and social care staff using feedback from previous public and patient engagement work. The result will be a shared view of how to meet the health and care needs of our communities.

2.3 There is compelling evidence that current ways of delivering care harm patients and wastes money. This is a consequence of failing to intervene early to help patients remain at home or return home from hospital as early as possible. The long term impact of this is significant, to both individuals and the wider health and social care system.

2.4 Staying any longer than necessary in hospital causes harm to patients – muscle function reduction, reduced independence & risk of infection. It particularly affects people who are frail and people who have dementia:

Frailty and Hospitalisation	Dementia
• Frailty is a heath condition related to the ageing process in which multiple body systems gradually lose their in-built reserves. • Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years • Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, e.g. an infection or new medication. • For older people in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. • Older people can quickly lose mobility and the ability to do everyday tasks such as bathing and dressing; loss of muscle strength is up to 5% per day • Prolonged hospital stays increase the risk acquiring infections or other avoidable complications	• Dementia is a common in older people admitted to hospital - around 42% of older patients in hospital have some degree of dementia. • People with dementia face additional risks through prolonged admission, over and above those posed to frail and elderly patients • The combination of a physical illness and a change in environment can be very distressing and confusing for the patient • People with dementia may have difficulty communicating their needs • In the hospital setting there is a high prevalence of delirium (66%) and also of other psychological symptoms: depression (34%), anxiety (35%), delusions (11%) and hallucinations (15%). • The impact of admission to hospital on someone with dementia may not be reversible, and the level of care they need may be permanently increased as a consequence

2.5 To build a picture of the usage of hospital beds in Devon, Public Health Devon undertakes an Acuity Audit. This is a measure of the use of beds on a particular day. Audits were carried out by Public Health at the Devon PCT in 2010, 2011 and Devon Public Health in 2015. The results show that approximately 40% of people in a community hospital bed have no medical need to be there. This means that they are receiving care that they do not need, and in the worst case scenario the stay itself could be harmful to their health.

The model of care

⇒ Comprehensive assessment to identify and support those most at risk of being admitted to hospital in an emergency

⇒ Single point of access and rapid response service - front and back end of the pathway - admission avoidance and expedited discharge

⇒ Building on what is already taking place; each intervention is an extension of work that is already happening in parts of Devon

⇒ Changing how we think and act - changes in system & process only part of the change – 'doing the same, better'.

⇒ Leading to changing the focus to prevention, population health & wellbeing. New focus & roles that span health, care and rehabilitation = 'doing things differently'.

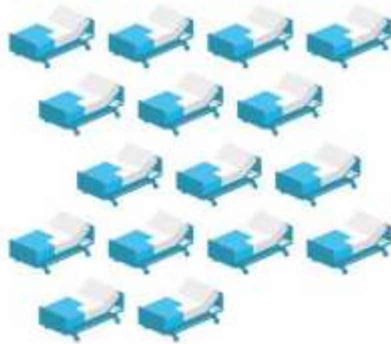
⇒ Trust, mutual understanding of risk and ability to share information are essential for successful integration.

2.6 The model of care is built upon the premise that people should be treated in their own homes where ever possible and that conditions that had previously required hospitalisation may no longer need it, or may not need it for as long. To achieve this change in culture, organisations will need to work together beyond boundaries. Culture in organisations and in society in general will need to be challenged. The spotlight review was informed that the proposed model addresses the issue of unnecessary and harmful hospital stays for the frail, elderly and those with dementia. It is based on three key interventions

Comprehensive Assessment	Single point of access	Rapid response
• Identifies people who are frail or becoming frail and more likely to be admitted to hospital • Puts plans in place that help people to be supported and remain well at home • Assessors act as 'community connectors' to support resilient communities	• Makes organising care at home as easy as care in hospital - and 24/7 • Referral can be made by any care service - with a clinical conversation based on patient need • A home-based 'first responder' service available within 2 hours to help support people to stay at home	• Multi-disciplinary team to respond to the needs of people at home and in residential and nursing homes • An initial assessment of need undertaken and a package of care at home applied • Rapid Response Team has access to additional capability and input - including through the acute sector

2.7 The model also enables improved use of resource by transferring resource and workforce from the provision of community hospital beds to the provision of enhanced home based care services more people can be supported. The case for the model of care is illustrated below.

A **16 bedded community hospital** unit **costs £75k per month** to staff for nursing



In one month, a unit like this cares for around 21 people

For **£75k**, the same level of care can be offered to clinically-assessed patients in their homes by **12 nurses, 8 therapists, 7 support workers plus some night sits**

In one month, this could care for around 82 people

3. Strengths/Weaknesses/Opportunities/Threats

3.1 In the spotlight review the general tenor was one of support for the theoretical model. Members welcomed person-centred-care which was individually tailored for the individual. However they did have concerns over how this was going to be achieved in every case across Devon in such a short timescale. The discussions in the spotlight review are represented over the page on the SWOT table. Whilst the SWOT tool gave an accessible mechanism for discussion with the nature of complex change there were, unsurprisingly, several issues that demand more discussion and explanation. These are detailed below.

3.2 Funding was raised as an issue across the session. This was in several parts. The initial driver for change was funding and sustainability concerns. Concerns were voiced about whether the new model of care could actually deliver the scale of changes required. The issue of transition funding was also raised. The spotlight review was informed that the Success Regime has already been able to agree a higher deficit total that is acceptable to Central Government. This is £50 million bigger than Devon would otherwise be able to have. Whilst this is still in the form of borrowing, it does provide liquidity and transition funding.

3.3 Members felt that in general the model de-medicalised treatment and viewed people as people. This heralds a culture change from 'what is the matter with me' to 'what matters to me'. The approach was also extended to thinking about how people are situated in their community against the backdrop of a strong prevention agenda. There is a future for social prescribing further to enable independence and community level interventions that make a difference to individuals.

3.4 The governance and the pace of change were both mentioned more than once in conversations. The answer was that the architecture will be developed as the process develops, that it is important to get the service right first then work on the structure. That releasing the resources first in a phased programme is the way forward. Some of these changes are already in place for example in Torbay, and some are yet to be developed. The model recognises that outcomes for people are the same, but population needs may be different.

3.5 Property ownership and disposal is a complex issue that has recently come to the fore. Questions over who owns what building and what might happen if the buildings are deemed to be surplus to requirements is a thorny issue. The estates strategy that is being prepared will be something that scrutiny takes an interest in. In the meantime understanding the precise ownership arrangements for each hospital may be very useful.

3.6 Several agencies working across traditional organisational boundaries for the best outcomes for a patient is going to be challenging. For a start the professional languages of social care when compared to the NHS are markedly different. Blending teams may mean that one skilled person comes to visit and takes account of all the care, rather than several specialists doing the same on a number of visits. Lone working might be a concern, yet currently there are eleven thousand care workers who currently visit people's homes on their own. In complex cases there are provisions for double handed care, but this is very much done on a case-by – case basis.

Strengths

- **Better outcomes for people.**
- **Value for money** for tax payer.
- **Patient centred approach** with a single point of access, considering the family with wrap-around services and a holistic approach.
- Potentia**l integration of Health and Social Care.**
- **Reduce pressure** on planned hospital treatments.

Weaknesses

- **Workforce**, are there enough staff and how will we recruit?
- Need to talk about **end of life care.**
- Current **capacity in nursing homes,** particularly for people with dementia.
- **Different agencies**: adult social care NHS commissioners/providers might mean that people fall between the gaps:
  - not integrated budget
  - not integrated technology
  - all agencies need culture change
- **Discharge** has been weak.
- Where is provision for **mental health?**

Opportunities

- Enhanced community role in wellbeing leading to more **resilient communities .**
- Act as a catalyst for **strong local leadership.**
- **Tackle health inequalities** by offering a uniform model of care.
- Using **councillors as ambassadors for change.**
- Focus effort on keeping people well and **prevention.**
- **Plan for the future workforce,** building on higher education offer in the region and cross skilling workforce.
- **Improve public health** across the life course to support self-directed care.

Threats

- **Rurality** and achieving the 2 hour response time.
- **How future-proof is the model** with further funding challenges, a continued increase in the age of the population and the complexity of conditions and further closure of local services like pharmacies?
- **Communication and understanding with the public**. There is great distrust around NHS change. There needs to be a change in attitude.
- **Implementation**: It is essential that interventions are timely. The new model will need to resolve delays to personal budgets.

4. Conclusion

Members In the room agreed that hard and difficult conversations need to happen. Change in the NHS is emotive and presents challenges for all who come into contact with the system. Fundamentally there was support for the model of care, for better outcomes for patients and for more intensive rehabilitation. However there are enduring concerns over exactly what this will mean in each location and whether the additional services and staff will be in place to make this happen in the short term.

One of the most insightful conclusions to come out of the meeting was the need for Councillors to be empowered with information in order to become ambassadors for change. This will require members to be well briefed and included as developments unfold. The three Scrutiny Committees will have an ongoing role as development of the STP continues and individual areas consult on changes. The three committees are the upper tier authorities and therefore will be statutory consultees on major change to the NHS. They will also have a role in ensuring that the voice of the public continues to be heard.

From now each authority's Scrutiny Committee can consider how they feed this collective piece of work into their scrutiny deliberations in the future.

5. Attendees

Members

The spotlight review was chaired by Cllr Richard Westlake with the following Members of the three Councils:

NAME	COUNCIL	ROLE
Cllr Frank Biederman	Devon	People's Scrutiny
Cllr Jerry Brook	Devon	Health Scrutiny
Cllr Rufus Gilbert	Devon	Health Scrutiny
Cllr Brian Greenslade	Devon	Health Scrutiny
Cllr Sara Randall Johnson	Devon	People's Scrutiny
Cllr Andy Boyd	Devon	People's Scrutiny
Cllr Margaret Squires	Devon	People's Scrutiny
Cllr Richard Westlake	Devon	Health Scrutiny
Cllr Claire Wright	Devon	Health Scrutiny
Cllr Debo Sellis	Devon	Health Scrutiny
Cllr Barbara Cunningham	Torbay	Community Services/STP Review Panel
Cllr Cindy Stocks	Torbay	Community Services/STP Review Panel
Cllr Neil Bent	Torbay	Community Services/STP Review Panel
Cllr Jane Barnby	Torbay	Community Services/STP Review

		Panel
Cllr Jackie Stockman	Torbay	Community Services/STP Review Panel
Cllr Nick Bye	Torbay	Community Services/STP Review Panel
Cllr Mary Aspinall	Plymouth	Chair of Wellbeing Scrutiny
Cllr David James	Plymouth	Vice Chair of Wellbeing Scrutiny

Witnesses

The Spotlight review was well attended with officers from across Devon from Councils, the CCGs and the Success Regime/STP team. The Members of the spotlight review would like to express sincere thanks to the following for their involvement and the information that they have shared.

Officer	Organisation	Role
Angela Pedder	Your Future Care (Success Regime) & Devon STP	Lead Chief Executive
Dr. Phil Hughes	Plymouth Hospitals NHS Trusts/ Devon STP	Medical Director
Dr. Simon Kerr	NEW Devon CCG	Eastern Locality Vice Chair and GP Lead
Rob Sainsbury	Northern Devon Hospital Trust	Executive Operations Director
Jenny McNeil	NEW Devon CCG	Associate
Jo Andrews	Carnall Farrar	Principal
Teresa Widdecombe	Your Future Care (Success Regime) & Devon STP	Programme Manager
Dr David Greenwell	South Devon & Torbay CCG	Chair of Community Services Transformation Group
Rebecca Foweraker	South Devon & Torbay CCG	Head of Commissioning for Integration
Tim Golby	Devon County Council	Head of Adult Commissioning and Health
Fran Mason	Torbay Council	Head of Partnership, People's & Housing

Special Mention must be made of Kate Spencer and Ross Jago, Scrutiny Officers from Torbay and Plymouth respectively, for all of their assistance in co-ordinating and carrying out this piece of work.

6. Contact

For all enquiries about this report or its contents please contact

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