PH/15/25

Health and Wellbeing Scrutiny Committee

14 September 2015

Safe and effective care within our budget: consultation

REPORT TO:	Devon Health and Wellbeing Scrutiny Committee
DATE:	14 September 2015
PRESENTED BY:	Depending on time of agenda item: Alison Diamond, Chief Executive or Rob Sainsbury, Director of Operations

1. Overview of the consultation

1.1. The purpose of this paper is to provide a briefing to Scrutiny Members on the process and feedback so far to the Northern Devon Healthcare Trust's *"safe and effective care within our budget"* consultation currently taking place in northern Devon.

1.2. At the time of writing (7 September 2015) the consultation is three weeks into its six week duration.

1.3. The consultation is in response to the 2015/16 budget settlement between NEW Devon Clinical Commissioning Group and the Northern Devon Healthcare Trust which resulted in an £11million gap in funding, £5million of which is allocated to the community services budget.

1.4. For the purposes of avoiding any confusion, this consultation proposes replacing the (average) 21 day stay in a community hospital for 34 beds (as indicated by NEW Devon CCG's strategic direction in July 2015) with care received in the patient's own home from our enhanced community teams. The focus for those patients is on rapid response to avoid unnecessary admission to hospital and rehabilitation in the home following a hospital stay.

1.5. The consultation leaves approx. 40 community beds remaining in North Devon (beds flex up and down according to demand).

1.6. Our modelling of health outcomes in places where beds have been reduced (Torrington and Ilfracombe in North; Moretonhampstead, Crediton, Ottery and Axminster in East) confirms that this out of hospital model of care is safe, appropriate and high quality for the majority of patients.

1.7. The Devon-wide System Resilience Group (SRG), made up of NHS providers and commissioners, has analysed the data and patient flows following the bed closures and support the out of hospital model of care and particularly the increased effectiveness of rapid response to the patient at home within 2 hours as compared to inpatient beds.

1.8. This consultation has no impact on the eligibility processes for continuing health care or long-term social care

2. The consultation process

2.1. The consultation launched on 18 August 2015 and runs for 6 weeks until 29 September 2015.

2.2. The Trust is consulting on how to transform its service to continue delivering high quality care within its budget.

2.3. This budget was only signed in month 3 of the financial year. The speed of the consultation is dictated by requiring any service change to be implemented safely before winter.

2.4. Prior to the consultation launch the Trust's Board members conducted pre-engagement roadshow meetings with our staff and selected stakeholders in June/July. In August, stakeholders were again involved through the Stakeholder Review Group meetings which reviewed, agree, scored and weighted the decision-making criteria. A full description of the outcomes of the pre-engagement is contained within the consultation document and attached in the supporting documents.

2.5. The consultation consists of three options

Option A: community inpatient beds located at two community hospitals

Option B: community inpatient beds located at NDDH

Option C: community inpatient beds located at NDDH and a community hospital

2.6. All of the seven public meetings (Ilfracombe, Holsworthy, South Molton, Bideford, Hatherleigh, Lynton and Barnstaple) took place in the first three weeks of the consultation allowing us to respond to invites from groups to also attend their meetings (i.e. GP Provider Forum, Bradford Village Hall, Torridge)

2.7. Approximate attendees at each meeting as follows:

Ilfracombe 18.08.15	70-80
Holsworthy 20.08.15	500-600
South Molton 25.08.15	150-175
Bideford 27.08.15	60-70
Hatherleigh 01.09.15	15
Lynton 03.09.15	20
Barnstaple 07.09.15	*to follow*

3. Consultation feedback to date (7.9.15)

176 consultation response forms

35 pieces of correspondence which have received a response

NB: NDHT staff are being encouraged to participate in the consultation

4. Key issues

The following issues have been raised during the first three weeks of the consultation. The Trust's response to each is briefly described under each.

4.1. Criticism of the consultation process

It is understandable that there are strong reactions to the content of the consultation. However, in process terms and due to the strong possibility that significant service change will be required to enable NDHT to remain within budget, there is no indication that the consultation is flawed in terms of process and none of the stakeholders have put forward a reason why it is flawed.

The Trust used Cabinet Office guidelines on standards of public consultation and incorporated the key recommendations on timing, materials and frameworks.

4.2. CCG withdrawal

The CCG's withdrawal from this consultation has caused disquiet amongst the community and appears to be the key reason people feel the process may be flawed.

The Trust is being very open and clear in response that whilst we would have preferred the CCG to be with us, we respect their decision to keep the consultations separately. In mitigation, we are stating:

- Any decision we make is reversible, so as not to prejudice the outcome of Care Closer to Home
- We are tasked with delivering safe and effective care within our budget every financial year; the CCG has a longer-term timeline for its strategy and this accounts for the differing timescales as the reason why the processes separated.
- The CCG supports NDHT's right to consult on ending the year in financial balance.

4.3. The lack of a 'do nothing option'

The do nothing option has patient safety and resilience issues that arise as a result of the high percentage of agency staff currently required to support our community hospital inpatient services. The petition by STITCH/DHAG/UNITE asks whether people support bed closures and fails to acknowledge that the current model is vulnerable to staffing shortages or that the alternative might offer better health outcomes for patients. In addition the 'do nothing' option is unaffordable and would put the Board at risk of failing its statutory duty of financial break-even.

4.4. Confusion about care, long-term / short-term

We are encountering confusion about the services on offer amongst healthcare professionals, stakeholders and the public. Long-term social and continuing health care are confused with short-term NHS-funded care.

4.5. We have the support of the health and social care managers (jointly funded NHS and DCC) at each public meeting and are asking them to describe how we can safely replace a 21 day stay in a community hospital with care in their own home – for more people. We are clarifying that any longer-term care needs after this point are assessed in the usual way.

4.6. GP input/support

Alison Diamond, Stella Doble, Nikki Kennelly and Katherine Allen attended the GP provider forum meeting on 25.8.15 to ensure GPs understood the consultation and could ask questions.

We intend to develop this dialogue to ensure that we understand any concerns so as to be able to address them within the planned mitigation (which depends on the consultation option chosen).

This process will also provide assurance to the CCG that their member GPs have been involved in the development of the mitigation should beds reduce in their town.

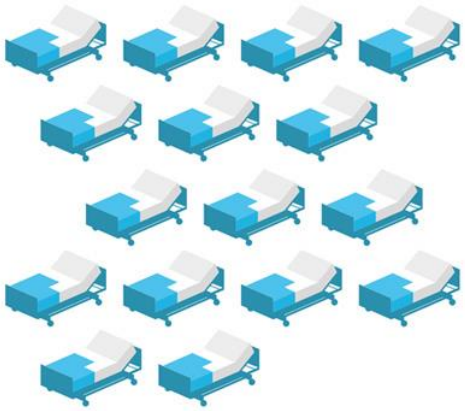
4.7. Confusion about finances

We are unable to be specific about the final cost saving because it depends on the configuration of the options and the level of mitigation that goes into the town(s) which lose beds. This varies per town and so we are working on the basis that we will save an average of £700,000 per hospital site, full year effect.

The model of seeing more patients in their own home is more cost effective because we can care for more patients with the same resource.

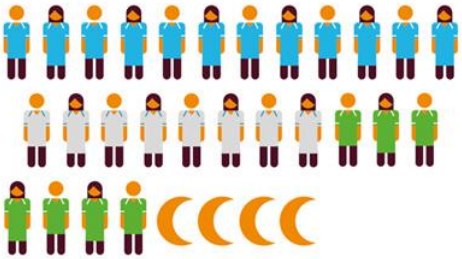
See overleaf for a comparison of the costs between a hospital and out of hospital model of care.

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

5. Summary

At this current time there are no indications that the consultation process requires amendment nor is there any evidence that people are unable to understand the scope and content of the consultation. Therefore, the public are able to influence and contribute to the outcome of this consultation.

It is our assessment that the Trust is running a robust and effective consultation as required under the 2012 Health and Social Care Act (duty to engage).

6. Decision-making process

6.1. By using decision-making criteria the Board has been careful not to establish a process which simply asked for the public to state the popularity of their local hospital. This would have resulted in a divisive consultation.

6.2. Instead, the consultation asks the public, stakeholders and our staff to use the decision-making criteria (see below) to justify their choice of option. In this way the public will be fully contributing to the decision-making process of the consultation.

6.3. The Northern Devon Healthcare Trust Board will use the information provided by responses to these criteria to inform its decision

6.4. In addition, there are a number of other 'essential criteria' which were not consulted upon because these are the statutory clinical or national standards to which all NHS providers are required to achieve:

- Statutory duty to operate within financial budgets, with increasing pressure on successful providers (NDHT included) from the Department of Health to increase its surplus
- Provide services which are clinically safe and high quality

7. Decision-making criteria

Ability to recruit and retain staff

Older people living alone

Accessibility and transport

Reducing health inequalities

Quality of buildings

Private sector availability of care homes

Flexibility for periods of surge (increased demand on services)

Changing demographics

Impact of any lost opportunities

8. Quality Impact Assessment

The Northern Devon Healthcare Trust has prepared a full QIA of the consultation options for the Clinical Commissioning Group.

This is attached as an appendix to this briefing report.

9. Supporting documents

The following documents are attached

- Consultation document
- Consultation presentation
- Meeting Q&As thus far
- Criteria weighting and scoring

Other information is available at www.northdevonhealth.nhs.uk/consultnorth

10. Equality and Diversity Implications

10.1. The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

10.2. We have provided the consultation materials in a variety of formats, chosen venues which are accessible and provided a variety of means by which to respond to the consultation.

10.3. Attendees of public meetings with a visual impairment are seated at the front. Those in wheelchairs are offered a convenient seat at a table.

10.4. No significant adverse or positive impacts have been identified.

11. Appendix 1 Quality Impact Assessment of safe and effective care within our budget