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

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

Date: 2 September 2020

Contact: Gerry Rufolo 01392 382299
Email: gerry.rufolo@devon.gov.uk

HEALTH AND ADULT CARE SCRUTINY COMMITTEE

Thursday, 10th September, 2020

A meeting of the Health and Adult Care Scrutiny Committee is to be held on the above date at 10.30 am to consider the following matters. This will be a Virtual Meeting. For the joining instructions please contact the Clerk for further details on attendance and/or public participation.

Phil Norrey
Chief Executive

A G E N D A

PART 1 - OPEN COMMITTEE

1 Apologies

2 Minutes

Minutes of the meeting held on 16 June 2020 (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 Proposed Structure and Governance Arrangements for Devon Integrated Care System (Pages 1 - 12)

Report of the Lead Chief Executive for the Devon Sustainability and Transformation Partnership (STP), attached

6 Adult Social Care Market Sufficiency Statement 2020 (Pages 13 - 32)

Report of the Associate Director of Commissioning (Care and Health) (ACH/20/127), attached

7 Consultation Modernising Health and Care Services in the Teignmouth and Dawlish area (Pages 33 - 66)

Report of Torbay and South Devon NHS Foundation Trust and NHS Devon Clinical Commissioning Group, attached

8 Devon System Covid-19 Response (Pages 67 - 72)

Report of the Associate Director of Commissioning (Devon CCG, Northern & Planned Care & Cancer), attached

9 Standing Overview Group: Care Homes Testing / Recovery & Restoration in the NHS (Pages 73 - 76)

Report of the Standing Overview Group meeting held on 31 July 2020, (CSO/20/16), attached

10 Scrutiny Committee Work Programme

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

The Committee may also wish to review the content of the Cabinet Forward Plan and the Children's Services Risk Register to see if there are any specific items therein it might wish to explore further.

MATTERS FOR INFORMATION

11 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.

(a) Torbay and South Devon NHS Foundation Trust Update: 21 August 2020 - Health & Adult Care Scrutiny Committee.

(b) Devon Partnership NHS Trust: Care Quality Commission Inspection - Health & Adult Care Scrutiny Committee.

(c) Torbay and South Devon NHS Foundation Trust Update: 7 August 2020 - Health & Adult Care Scrutiny Committee.

(d) Modernising Health and Care Services in Teignmouth and Dawlish: briefing by NHS Devon CCG on the future of health and care services in Teignmouth and Dawlish.

(e) Torbay and South Devon NHS Foundation Trust Update: 24 July 2020 - Health & Adult Care Scrutiny Committee.

(f) DCC Adult Social Care Briefing – 6 July 2020.

(g) Devon STP CQC Review – Press Release.

(h) CQC Report on Torbay and South Devon NHS Foundation Trust - Health & Adult Care Scrutiny Committee.

(i) Response to Members Questions - 16 June 2020 Health & Adult Care Scrutiny Committee.

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 exempt information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s). They need to be disposed of carefully and should be returned to the Democratic Services Officer at the conclusion of the meeting for disposal.

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For the terms of reference for any Committee, please visit the Committee page on the website and click on the name of the Committee. Under purpose of Committee, the terms of reference will be listed. Terms of reference for all Committees are also detailed within Section 3b of the Council's Constitution.

Access to Information

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It is to be noted that Members of the Council 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.

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Induction Loop available

Health and Social Care Overview and Scrutiny Committee
10 September 2020

Proposed Structure and Governance Arrangements for Devon Integrated Care System

Report of the Lead Chief Executive for the Devon sustainability and transformation partnership (STP)

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1. Introduction and Context

1.1. The NHS Long-Term Plan set the ambition that every part of the country should be an integrated care system (ICS) by 2021. It encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations and offer well-coordinated efficient services to those who need them.

1.2. NHS England and NHS Improvement (NHSE/I) set out a consistent approach to how systems are designed highlighting three levels at which decisions are made and described the broad functions to be undertaken at each level:

1.2.1. Neighbourhoods (populations circ. 30,000 to 50,000 people) served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services through primary care networks (PCNs).

1.2.2. Places (populations circ. 250,000 to 500,000 people) served by a set of health and care providers in a town or district, connecting PCNs to broader services including those provided by local councils, community hospitals or voluntary organisations.

1.2.3. Systems (populations circa 1 million to 3 million people) in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale. An ICS is not a legal entity and has no authority and powers other than those afforded it by its constituent sovereign organisations that are the NHS and Local Authority (LA) organisations in the area.
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Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

1.3. More recently, "the Phase 3 letter" from NHSE/I received on 31st July 2020 set out the following requirements for systems:

"Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.
- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed

governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.
- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health."

2. Current position in Devon

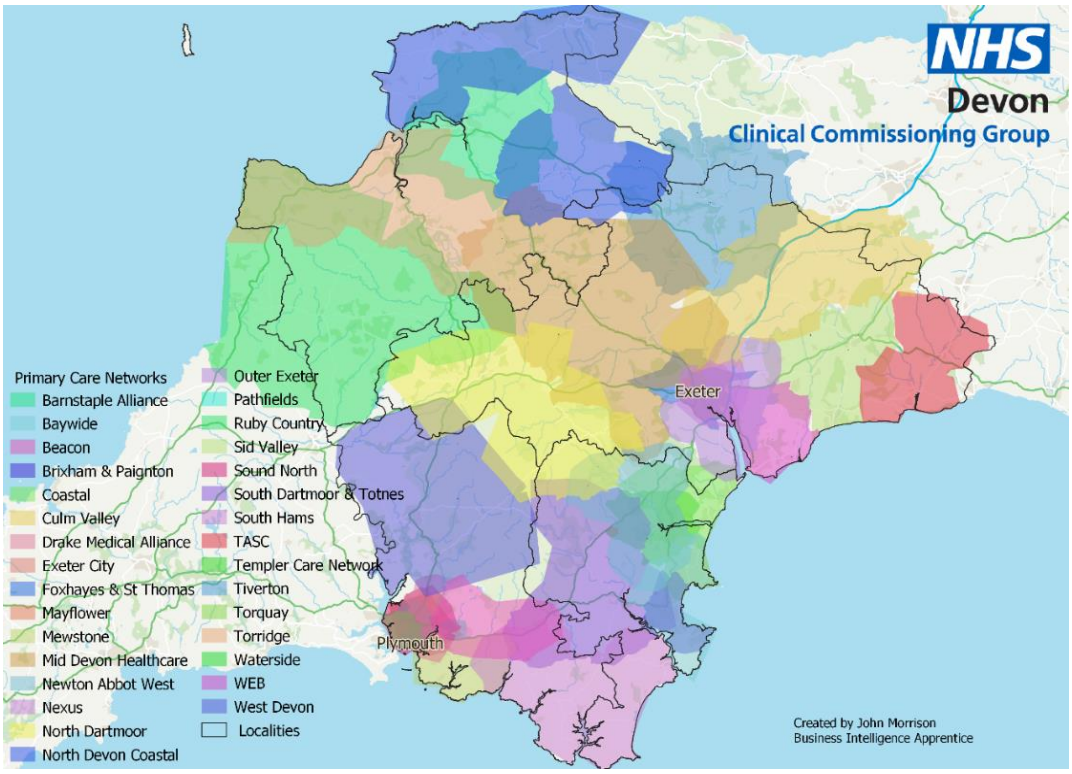
2.1. In Devon this new mechanism for setting strategies and developing and implementing plans to improve the health of a whole population is in the early stages of evolution. At system level Devon is currently a Sustainability and Transformation Partnership (STP), the precursor to an ICS, and has been since 2016.

2.2. NHS England have published a maturity matrix to support the design of integrated care systems (ICSs) in England. The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally named an ICS, they will need to meet the attributes of a maturing ICS1, assessed by the regional office of NHSE/I, which includes delivering performance and financial outcomes that meet plans agreed with NHSE/I. We are anticipating meeting the deadline of April 2021.

2.3. The development of informal structures for working "at place" is also at early stage with different approaches and levels of progress in each of the 5 Local Care Partnership (LCP) areas. There is a clear commitment across the county that place arrangements need to be suited to the circumstances and priorities of each place and there will be no centrally imposed governance structure. However, it is important that each place is able to demonstrate that it has the capacity and capability to deliver on its objectives before it's accountability and budgetary responsibility can be increased. Each LCP has a Development Lead who is co-ordinating and supporting this work.

2.4. From the 1 July 2019, 31 PCNs came into being so creating the "neighbourhood" tier.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf



2.5. Each PCN has a Clinical Director and within each LCP there is a Primary Care Collaborative Board that brings together all the PCN Clinical Directors in the area to provide an opportunity for collective consideration of issues as required. In the early stages the priority for PCNs is to offer a way of stabilising primary care and improve access for the population.

3. Developing the Governance and Accountability Arrangements

3.1. It is the role of the ICS to set the governance and accountability arrangements across the system that support each level to fulfil it's function. Consultation with all partners in the ICS has identified a number of principles for these arrangements as set out below:

- System governance needs to be light touch with minimal bureaucracy.
- Arrangements need to be flexible, responsive and emergent.
- The ICS recognises existing and continuing statutory roles and responsibilities.
- The ICS, engaging with all system partners, is responsible for setting strategy, direction and policy. The ICS will make recommendations to statutory organisations where required.
- There is an imperative to establish new arrangements but recognition that initial arrangements may be subject to change pending future NHSE guidance/ gateway criteria. This is an evolutionary process.

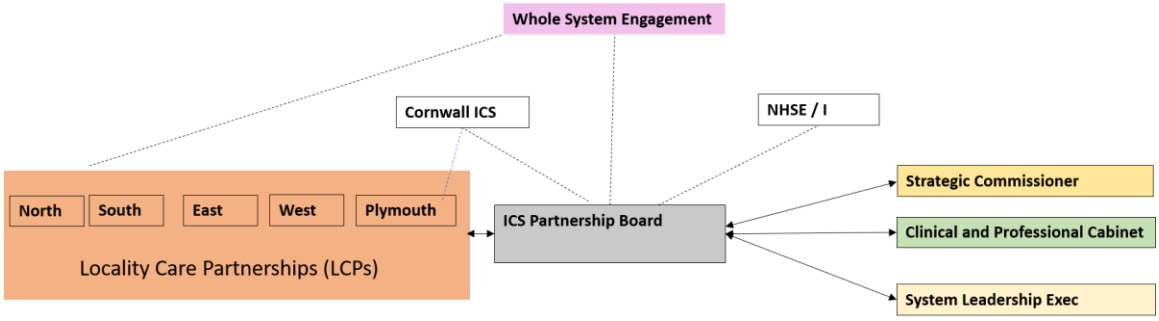
- The principle of subsidiarity is accepted and all partners will hold each other to account for working to this principle. Subsidiarity means that the delivery of integration is happens as close to the citizen as possible - at Place or Neighbourhood. System activity is reserved for when the objectives of an action can be better achieved at system level by reason of the scale and effects of the proposed action or when an action is required by regulators.
- System and place will work together to drive transformation at all levels.
- Meetings will be held virtually whenever possible.

3.2. The overall structure, delivery architecture and governance of an ICS is currently not mandated, and nationally each system is developing its own model. It is possible that there may be some mandated national alignment about the nature and structure of an ICS and all associated governance at a future date but, as outlined in the principles above, the Devon system partners are keen to establish new arrangements to ensure that the momentum and engagement are not lost. Discussions with NHSE/I suggest that the arrangements proposed within this document will be in line with any future requirements.

3.3. Interim governance arrangements were established in 2019 but this way of working was put on hold during the COVID incident. A review of these previous arrangements has been undertaken in light of new approaches to partnership working across health and social care during the COVID incident and there has been an opportunity to learn from past experience, both in Devon and more widely.

3.4. Discussions with individual organisations and their leaders were used to develop a draft structure which was also shaped by a review of arrangements in other systems. This structure was refined through further discussions and two system-wide meetings involving Chairs, Council Leaders, CEOs and place development leaders to produce this document. On 31st July 2020 this group agreed that a Shadow Partnership Board should meet for the first time early in September 2020.

3.5. Following discussion with NHSE/I this document will be socialised more widely with other system stakeholders for feedback before the first Shadow Partnership Board meeting. Subject to approval it will then be shared with organisational Boards and Cabinets for formal approval.



(A more detailed structure is shown at Appendix B)

3.6. The ICS Partnership Board will consist of

- Health Chairs / Council Leaders,
- Health CEOs /Council CEOs
- System CEO
- Chair Clinical and Professional Cabinet

3.7. It will be responsible for:

- Setting system strategy, direction and policy.
- Strategic planning and consideration of the proposed resource allocation
- Strategy Development (e.g. Social Care, Community Care, Procurement (procuring locally))
- Sharing, scaling and spreading good practice
- Solving wicked system issues (such as system infrastructure, competing priorities etc.) and enabling development at place.
- Influencing and strengthening Regional and National links
- Championing Equality and Challenging Inequality
- Citizen Engagement working with Place and individual organisations to prevent duplication of effort.

3.8. The Partnership Board will work closely with the following groups to ensure delivery of system wide objectives and ensure a robust framework for planning and performance management:

- System Leadership Executive
- Clinical and Professional Cabinet
- Strategic Commissioner

3.9. The Partnership will not replicate the Boards or Cabinets of the Health and Social care organisations as its role is not to provide or commission services. There were concerns that if it did in any way replicate those structures that it may start “doing” as opposed to setting a framework for

others to "do" within and create a conflict with the function of LCPs and at neighbourhood with Primary Care Networks (PCNs).

3.10. The Terms of Reference for the Partnership Board are at Appendix A

Working at Place

3.11. Local Care Partnerships (LCPs)will lead the delivery and development of services at place level. Their constituent organisations will take responsibility for a range of functions, previously assigned to providers and commissioners to ensure that services meet the needs of the local population and population health is improved.

3.12. The LCP is an arrangement for joint leadership of multifunctional teams, integrated by a shared plan and objectives, common processes and deployment of joint resources.

3.13. The aims of the LCPs are to

- Deliver Devon system strategies at local level
- Improve health and wellbeing outcomes for the local population
- Reduce inequalities
- Improve people's experience of care
- Improve the sustainability of the health and care system
- Support local engagement including with PCNs

3.14. In order to achieve these outcomes the LCPs will -

- Co-produce plans with ICS Partnership Board which will deliver improved health and care services at population level;
- Develop integrated services;
- Create the conditions for healthy living;
- Manage resources within available budget;
- Plan services through engagement with citizens;
- Develop community assets.

3.15. It is recognised that the success of LCPs will be dependent on a wide network of relationships within a local area. Culture and the approach to working together will be as important as the formal structures. Therefore the membership of the LCP leadership team will be based on local circumstances but should include at a minimum-

- Local Provider Organisations (Health and Care);
- PCN Clinical Directors;
- Local Authorities (officers and elected members) to include social care provision, housing, employment and communities;

- Public Health leadership;
- Community, Voluntary and Social Enterprise Sector;
- Independent Sector.

3.16. LCPs should also be able to demonstrate clearly how they will work with Health and Wellbeing Boards and Scrutiny Committees.

Appendix A

Devon Shadow Integrated Care System Partnership Board

Terms of Reference

1. Introduction and Purpose

1.1. The Integrated Care System (ICS) Partnership Board will be responsible for setting the overarching vision and plan for the Devon Health and Care system and for holding the system accountable for delivery.

2. Aims and Responsibilities

- To agree the Devon Health and Care System strategic vision, ambitions and priorities in line with the Long Term Plan.
- To set the framework within which the system will operate. This will support flexibility for working at place and local decision making whilst having standardised approaches to improving efficiency.
- To consider commissioning intentions, set by the strategic commissioner seeking to influence and align them with system strategic plans and see they are reflected in local Place based plans.
- To inform and engage patients, the public and staff and their representatives in the work of the ICS.
- To consider and give a view on the proposed Capital and Investment Strategy and funding allocations and criteria where required.
- To receive regular update reports from the System Leadership Executive on the ongoing process of delivery of the Long Term Plan and associated delivery plans.
- To agree the Devon ICS Outcomes Framework as developed by the Strategic Commissioner.
- To oversee an annual review of the Long Term Plan and the development of annual delivery plans.
- To hold the system to account for quality and performance.
- To develop strong relationship with Regulators and wider Health and Social Care System and ensure that the system complies with regulatory duties and assurance reporting requirements.
- To develop and maintain relationships with organisations outside Devon where this is appropriate to support delivery of objectives.
- To work across system to promote provider resilience and to co-ordinate response in the event of failure.
- To advise and act upon key strategic issues and risks on performance delivery and transformation of the Devon System.
- To share good practice and promote its spread.
- To provide a forum for solving “wicked issues” .
- To act as the Devon Champion for Equality and Diversity.

3. Membership

- System Independent Chair
- System Chief Executive
- Chief Executive and Chair of all health organisations in the ICS
- Council Leader and CEO of each of the Local Authorities in the ICS
- Chair of the Clinical and Professional Cabinet

4. Frequency

4.1. Meetings will be held monthly and will be planned for the calendar year ahead.

5. Meeting Review

5.1. A review of the efficiency of the ICS Board and delivery of its responsibilities will be undertaken at least annually in line with annual refresh of system governance arrangements. A review of the membership of the Partnership Board will take place roughly six months from the first meeting of the Board.

6. Reporting

6.1. The ICS Partnership Board is accountable to NHSE and NHSI on regulatory and oversight functions currently exercised outside of the system and will report accordingly.

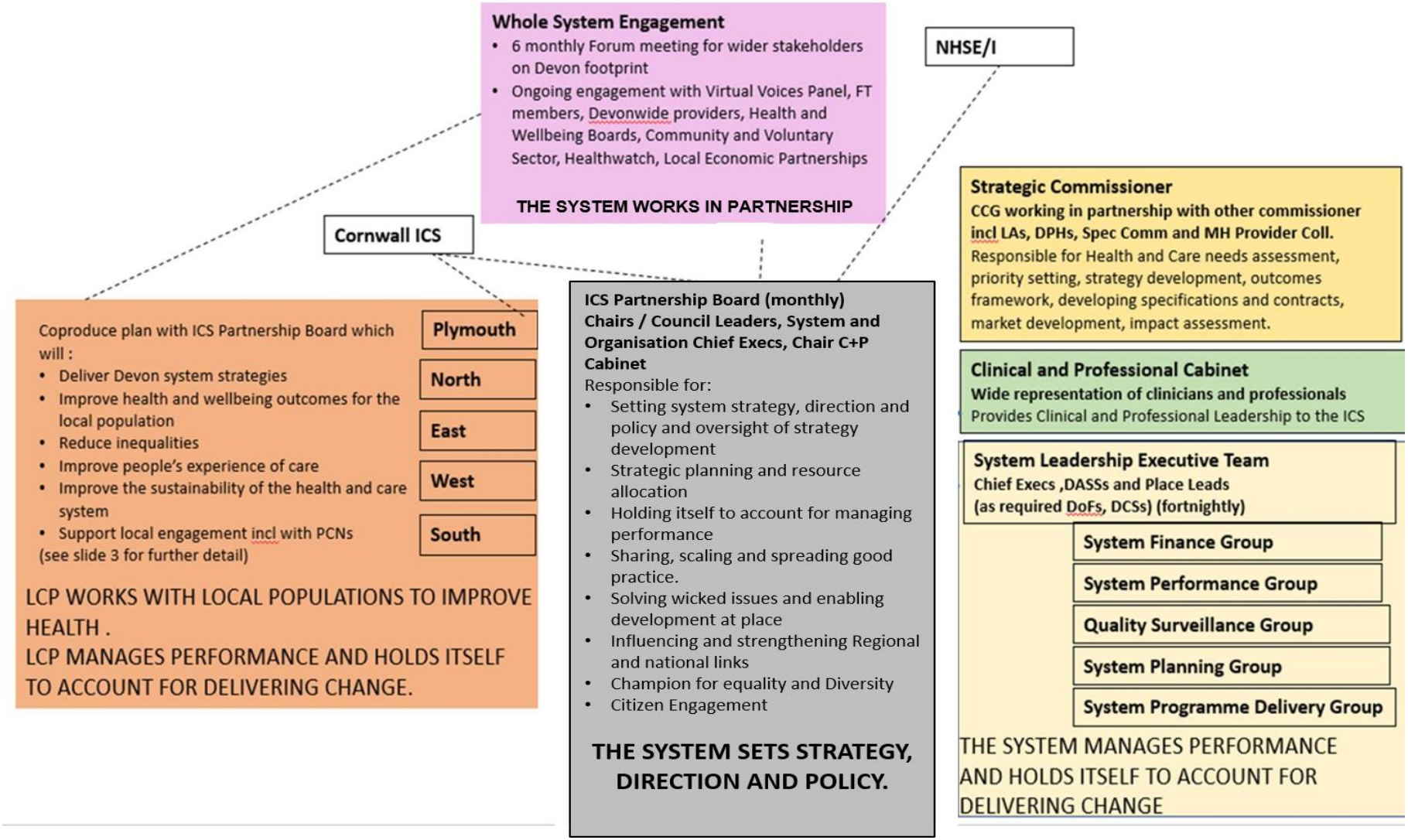
6.2. The ICS Partnership Board is the system's principal governance forum but it is not a statutory body.

6.3. The ICS Partnership Board will operate on the basis of consensus decision making. The Independent Chair will promote this model of working.

6.4. The ICS Partnership Board will work closely with the following groups to ensure delivery of system wide objectives and ensure a robust framework for planning and performance management:

- System Leadership Executive
- Clinical and Professional Cabinet
- Strategic Commissioner

Appendix B – Detailed Governance and Accountability Structure



Electoral Divisions: All Division.

Contact for Enquiries: Philippa Slinger, Lead Chief Executive Devon STP (D-CCG.CorporateServices@nhs.net)

Local Government Act 1972: List of Background Papers

Background Paper	Date	File Reference
N/A		

ACH/20/127
Health and Adult Care Scrutiny Committee
10 September 2020

ADULT SOCIAL CARE MARKET SUFFICIENCY STATEMENT 2020

Report of the Associate Director of Commissioning (Care and Health)

Please note that the following recommendations are subject to consideration and determination by the Cabinet (and confirmation under the provisions of the Council's Constitution) before taking effect**.**

1. That the impacts on the adult social care market of Covid-19, together with associated financial risks, are taken into account as part of budget preparation (section 3 and 5)

2. That the Cabinet endorses the actions being taken to address sufficiency and to remodel key sectors of the market (section 3 and Appendix 1).

3. That the Cabinet agrees that detailed proposals are prepared supported by the Cabinet Member for Adult Care and Health, to lead a high profile campaign locally and nationally to secure a social care workforce that delivers the high quality care and support to which we aspire, through improved terms and conditions and other measures (see section 4).

1. Background/Introduction

1.1 At its meeting on 15 January 2020, Cabinet required (minute 448) that a Market Sufficiency report be presented each September.

1.2 This report was presented to Cabinet on 9th September 2020 and is now presented to Scrutiny for further consideration. Market Sufficiency and development is an ongoing iterative process and Scrutiny are invited to further comment on this report.

1.3 This report details the initial impacts of COVID19 on adult social care markets and sets out actions to respond to them.

1.4 The January 2020 Market Position Statement (MPS) is available at https://www.devon.gov.uk/providerengagementnetwork/statements/ and will be updated in the coming months where change is indicated.

2. Strategic Context

2.1 The pandemic has reinforced the importance of the adult social care sector to the safety and well-being of the people of Devon and demonstrated the

strong partnership between the Council, the NHS and our independent sector provider partners.

2.2 Our health and care system has performed very well throughout the pandemic. The rapid and sustained action taken to support providers has been fundamental to that success and has built a strong platform to address future challenges.

2.3 Nevertheless, the impact on the adult social care market has been significant and, in preparing for Winter, we need to address new challenges and assess future risks, especially in relation to service models, provider infrastructure, pricing and workforce.

2.4 Those markets identified in January as presenting the greatest risks to sufficiency (care homes and domiciliary care) remain high priority but increased focus is now also needed in relation to:

- buildings-based day services, many of which cannot safely continue with historic models of service delivery
- the Supported Living market, due to the increased risk of Covid-19 in shared accommodation
- replacement care, due to increased pressures on unpaid carers.

2.5 A strong care workforce is key. The pandemic has presented major difficulties for providers, but the care sector now has a much more positive profile and, coupled with rising unemployment, the potential to attract and retain staff. This is illustrated by our successful Proud to Care campaign which resulted in approx.150 new recruits.

2.6 The Council's increased investment into the pay of domiciliary care workers and commitment to review pay and conditions in care homes as part of the 2021/22 fee review, has been widely welcomed.

2.7 Our sufficiency plans will balance strategic market assessments with place-based commissioning so that we reflect local conditions.

3. Market Sufficiency Assessment

3.1 This section sets out 5 priorities

3.2 Running through them is the need to address the needs of a relatively small number of people who have the most profound needs, especially those with physical and learning disabilities, enduring mental health needs and autism. The solutions for this group are often highly bespoke and represent the highest individual cost of provision, potentially over a long period of time.

3.3 Care Homes

3.3.1 The Care Homes market has been heavily impacted by the pandemic but has responded well and has had fewer deaths than national experience would have indicated. This is recognised nationally.

3.3.2 In February 2020 the average vacancy rate of CQC registered beds was approx. 4%. In August 2020 vacancies have risen to 8%. The southern locality currently has the highest number of vacancies of both residential and nursing beds at 10%. However, homes which provide a service to support complex dementia have a much lower vacancy rate at approximately 3%.

3.3.3 Whilst the number of placements made by the Council and NHS has been consistent, or even higher than usual, the number of self-funders taking up care home placements appears to have fallen. This may be masked by NHS funded placements as part of the COVID-19 hospital discharge guidance. This has meant that all individuals have had state funded care placements throughout the current escalation period.

3.3.4 It remains difficult to place people with complex needs and behaviours that challenge services.

3.3.5 Ensuring sufficient staffing to deliver enhanced levels of care to support the self-isolation of people newly admitted to care homes (in line with infection control guidance) is difficult for some homes.

3.3.6 The average cost per bed has increased in both residential and nursing care, creating a budget pressure. This is common across the region.

3.3.7 Continued risks and issues in this sector include:

- varying levels of vacancies but up to 30% in some homes, made more acute where there has been an outbreak, bringing associated financial pressures and increased risk of provider failure
- high running costs linked to PPE and higher staff levels
- the impact of any second wave and the ongoing costs of infection control and testing
- potential for more nursing homes to de-register nursing beds as they struggle to recruit and retain nursing staff.
- insufficient capacity if the market shrinks rapidly but demand returns to pre- covid19 levels
- seasonal pressures may be more intense, especially this winter, due to the combination of Covid and the usual flu season.
- care Homes have largely stopped delivering day care and respite care, further impacting on income streams (although continued financial support has been offered in relation to day services)

- a skills shortfall in those working with people with complex needs and nursing
- increased costs to address pay and conditions in the 21/22 fee review

3.3.8 Our priority actions in this sector are:

- Maintaining flow through the hospital system
- Supporting on-going infection control measures
- Reassessment of demand profiles
- Preparation of a Market Development Plan to address winter pressures and longer-term rebalancing of the market
- Increasing capacity for people over 65 with complex mental health needs
- Reviewing capacity for people under 65 with complex needs, physical disabilities and behaviour which challenge services
- Facilitating the Nursing Associate Apprenticeship Scheme, alongside other workforce initiatives in partnership with the NHS.

3.4 Regulated (domiciliary) Personal Care

3.4.1 In February 2020 there was a shortfall of 3,000 hours per week (6% of total commissioned hours) affecting 300 people, 50% of which was in Exeter and South Devon.

3.4.2 Demand reduced from April-June but has climbed steadily during July and August. The current shortfall is 2,365 hours per week, affecting 190 people (5% of total commissioned hours). The highest areas of unmet need are Mid Devon, East Devon and South Devon.

3.4.3 The additional permanent investment in the pay of domiciliary care workers should have a positive impact on retention and recruitment and improve sufficiency during the Autumn.

3.4.4 This action, together with further measures that will be needed, is crucial as the capacity tracker developed by CQC highlights that Devon stands out regionally and nationally as an area where providers are reporting major difficulties in securing sufficient staffing.

3.4.5 The key issues and risks affecting this sector include:

- Insufficient availability of care (and other) staff
- A changing pattern of demand, as we try to meet the needs of more people in their own home, often with more complexity and frailty
- Maintaining hospital flow requires new approaches to supporting admissions and discharges.
- The need for a faster response, often with bigger packages of care
- Uncertainty of demand patterns during the winter

- Reliance on costly agency staffing in Exeter, Mid and South Devon. Failure to reduce or replace will increase costs over winter.
- Managing complex and challenging behaviours requires new skills
- Challenges in offering double-handed and end of life care and in reaching some rural areas
- Increased demand for replacement care (day and night sitting) arising from reduced availability in care homes and day centres
- Changing patterns of support by unpaid carers and increased pressure on supply as those who have cared for relatives whilst furloughed return to employment
- The 5 year Living Well at Home contract ends in July 2021

3.4.6 Our priority actions in this sector are:

- Increasing workforce capacity
- Continuing action to reduce the numbers of people waiting for care
- Reassessing demand profiles and preparing for winter
- Building on our investment in the care workforce to strengthen its skill base, improve retention and boost recruitment
- Phasing out agency staffing, potentially through new block contracts
- Planning for future arrangements for the Living Well At Home contract after July 2021, including potential for efficiencies in the delivery model

3.5 Replacement Care

3.5.1 The reduced access to replacement care during the pandemic has had a significant and continuing impact on the wellbeing of unpaid carers.

3.5.2 Whilst demand is increasing, traditional forms of replacement care have reduced (already insufficient before the pandemic) in care homes and day centres.

3.5.3 The key issues and risks in this sector are:

- Increased risk of carer breakdown and safeguarding concerns arising from the increased intensity of the caring role
- Greater impact on the mental health and well-being of carers, exacerbated by their increased isolation
- Potential increase in the number of carers in crisis and longer term unbudgeted spend
- More difficult environment to develop replacement care solutions
- Impact on employment if unpaid carers cut back their paid work hours or give up their jobs, together with associated hardship

3.5.4 Our priority actions in this sector are:

- Increasing supply through an invitation (August 2020) to providers to join a list of services offering replacement care
- Market Development arising from that offer
- A focus on innovation, informed by the experience of unpaid carers
- Consideration of the potential for family-based and live-in care

3.6 Day Opportunities

3.6.1 Unregulated care and support is largely delivered through a "Supporting Independence" contract, which is structured in 2 lots:

- Lot 1
  Day opportunities (group based) – including building-based day care.
- Lot 2
  Care through the front door or individualised support – this is support which is not regulated personal care.

3.6.2 105 providers offer day opportunities. As a result of COVID19, approximately 30% of these providers may withdraw their service due to issues of safety and sustainability. This reflects national trends and is likely to impact mostly on older person's day opportunities.

3.6.3 Devon County Council respite centres closed during the COVID19 pandemic with staff reallocated into other activities such as enabling. Bed-based care in these centres re-opened from 17 July but day services remain under review, whilst we consider how we can provide services safely and in line with COVID19 guidance.

3.6.4 Financial support from the Council for day opportunities providers is available until the end of September, regardless of whether they are currently providing day care, to allow time to review their position.

3.6.5 For some time it has been a priority to improve support in the unregulated market for people with disabilities, mental health needs and autism. A further 20 providers entered our contract before the process was delayed because of Covid-19, and this remains a priority.

3.6.6 Key Risks and Issues facing this sector are:

- Likely closure of day centres, especially for older people
- Managing the transition from buildings-based day care to small-group or individualised solutions, which is likely to be at higher cost
- Loss of day care provision may have a significant impact on the wellbeing of unpaid carers

3.6.7 Our priority actions in this sector are:

- Opening the Supporting Independence framework (August 2020), with new providers operational under the contract from 1 April 2021
- Financial support to day opportunities providers until end September 2020 to either enable them to safely re-open or to adapt or close their services in a managed way
- Re-commissioning of the Supporting Independence (SI) framework, which ends on 30 September 2021.
- Consideration of the future of day service provision offered by the County Council.

3.7 Supported Living

3.7.1. Due to the extensive work undertaken during Covid19 to support this sector, our understanding of existing provision (comprising the care and support and the properties into which this is delivered) is much improved. However, more understanding is needed of future demand. This is a key action for our Housing with Support strategy.

3.7.2 As at 13 August there were 348 Supported Living properties with 1678 rooms in the County Council area. 67 providers deliver care and support to multiple service users living in these properties. 115 rooms are potentially available, depending on the match of the needs of new referrals and other tenants.

3.7.3 Whilst this market has been stable during Covid-19, it remains difficult to identify appropriate care and support solutions for people with mental health needs or with complex behavioural needs and for low-level, step-down transition support.

3.7.4 Key Risks and Issues facing this sector are:

- The serious risk of community transmission of Covid 19 in shared environments, mitigated by the Council's allocation of £1.6m from the Infection Prevention and Control Fund to the sector
- The need for more specialist capability, particularly for people with mental health needs and behaviours that challenge services
- The need for a wider range of appropriate accommodation solutions
- Financial sustainability, given the structure of this market where the tenancy and landlord function is separate to the care and support function, and with an increase in large national property investment organisations entering the market.
- Financial sustainability arising from future housing benefit decisions, including enhanced housing benefit that currently supports many people living in this marketplace.

- Staff shortages and skill gaps required to support the breadth of needs and complexity of service delivery.

3.7.5 Our priority actions in this sector are:

- Ensuring appropriate staffing levels, especially when staff work across various properties, to reduce risk of Covid transmission between settings
- Enhancing training, technology and other support to mitigate infection control risks
- Developing specialist capability with providers to match crisis support needs, complex behaviour needs and transition support.
- Work with providers to:
  - prevent hospital re-admissions and support discharge
  - reduce the number of out of county placements
  - increase the number of providers taking new placements out of office hours
  - increase resilience and develop strong business continuity plans
  - enhancing skills to meet specialist needs including mental health, autism and complex needs
- Work with District Councils and landlords to improve the supply of appropriate accommodation options.

4 Transforming the Independent Sector Workforce

4.1 Context

4.1.1 The pandemic has brought the social care workforce into the heart of debates about public policy but, wider social and economic concerns may overwhelm that shift.

4.1.2 The action by the Council to increase pay for domiciliary care workers and to commit to reviewing pay for care home workers in 2021, has provided a potential springboard from which to build. There is a once in a generation opportunity to make a transformational change to the expectations, performance and rewards of this sector.

4.2 The Opportunity

4.2.1 Our population expects and deserves high quality services, driven by training and skills, stability and values-based practice and leadership.

4.2.2 Devon's performance during the pandemic has been recognised nationally. Our demographic profile, together with our scale and strong relationships with our provider partners in both the NHS and independent sector gives us a platform from which to build a radical new approach to our workforce and, through it, to transform outcomes for the people of Devon.

4.2.3 As the Council establishes its recovery plan to address the consequences of Covid we need to ensure that social care is a core element of that programme of change.

4.3 Why is change needed?

- Our workforce is not sufficient, resilient or ready for future challenges
- It does not feel respected or valued and providers struggle to grow
- The nature of provision is changing and, arguably, the pandemic will be a catalyst for a long - term structural change in our markets
- Need is changing, becoming more complex and intense
- The public has different and changing expectations
- Our services need more agility to respond to wider system performance and to demographic, social, cultural and scientific developments
- The impact of Brexit and specifically the reduction in workforce from overseas and the expectation of government that we develop our own solutions to ensuring a workforce that is skilled and sufficient for the future.

4.4 What might a transformed social care workforce look like?

4.4.1 It would be:

- A workplace of choice – attracting people, not just because they have the right values but because it offers sufficient financial rewards to make it a viable economic choice
- A career of choice – because entrants can see a range of pathways of opportunity
- Respected and valued – not just by those who work in it but by the public at large; seen as a vital and vibrant part of our local community
- Driven by research and development – looking optimistically to the future and built on ethical practice, evidence, training, science and technology AND
- It would lead nationally – recognised for its innovation and leadership. It would maximise assets in science and production and transform health and care as we move from care settings to places and communities.

4.5 What prevents this happening now?

- Lack of commitment – the sector has not been high priority for a unified approach politically, economically or socially
- Lack of value – social care has not been seen as important and of value, certainly when compared to the NHS
- Lack of reward – investment in pay and conditions has lagged and does not reflect work that is valued
- Lack of economic impact – seen as a sector of high employment but low value and low economic return on investment.

4.6 How could things be different?

4.6.1 Devon County Council could seize the initiative and build a social care sector that is ready to address the challenges of the next 30 years. To do so the Council would need to assert its leadership and influence to:

- Engage a broad coalition of local, regional and national partners and
- Prepare a Prospectus for Change with a programme for the next 5 years which positions Devon as the vanguard of change

4.6.2 The “Prospectus for change” would need

- Political commitment – in the Council, through its MPs and with central government, including APPG
- Policy commitment – through ADASS, LGA and CCN
- Professional commitment - supported by Professional and Trade Bodies and Trades Unions.
- System commitment – STP benefits from sufficient markets, built on shared purpose, collaboration and trust
- Economic commitment:
    - Locally - consolidate the Council and NHS action to improve pay and conditions in the domiciliary care sector and recognise the investment that would be needed following a review of care home pay and conditions. For providers, the workforce acts a foundation for business growth and development
    - Regionally – working with the LEP to achieve a sector of high added value, engaging advanced industries in robotics, AI, green energy and backed by significant investment
    - Nationally – taking the case to government for the necessary investment
- Environmental commitment – recognised as a major contributor to carbon reduction, through use of e.g. electric vehicles to reduce carbon-based fuel consumption. Link to the “Go Green” programme.
- Social commitment – by engaging and harnessing public opinion to value the sector
- Educational commitment – combining the energy of the further and higher education sector to build a Social Care Academy in the county, nationally unrivalled that would be seen as a centre of research and development and learning.

4.7 This programme would need to be delivered through a high - profile national, regional and local campaign

5 Consultations/Representations/Technical Data

5.1 The provider representatives on our Provider Engagement Network Reference group have had an opportunity to comment on this report. Service Users, Carers and the general public are consulted separately where any significant changes to policy or service delivery are proposed or implemented.

6 Financial Considerations

6.1 There are significant risks of increased cost pressures to address the challenges set out in this report, the most significant of which are:

- The aspiration for greater investment in the workforce, especially but not exclusively as part of the care home fee consultation for 2021
- The potential for rising unit prices, to address the specific and unavoidable costs still present from the pandemic, for example items such as PPE
- Provider fee adjustments to reflect the changing context in which they operate and offset the number of voids they are carrying
- Changing models of care leading to higher costs e.g. relatively inexpensive day care may have to be replaced by 1:1 or small group work
- Increased risk of business failure may lead to an increase in demand for supplier relief or alternative service provisions
- The uncertainty of future government support to address the ongoing costs from the impact of the Covid 19 pandemic over the spring, and furthermore any further waves of Covid-19
- Large numbers of service user reviews will need to be undertaken to address government requirements in relation to funding for hospital discharge and providers seeking price increases.

6.2 It is not yet possible to assess the level of cost implication in each priority area, these will be considered as part of the detailed work that results from the Sufficiency Assessment and for budget preparation.

7 Legal Considerations

7.1 This annual Sufficiency Statement has been prepared to update the MPS with the latest position. The MPS is prepared as part of the Council's duty of Market shaping under the Care Act 2014.

8 Environmental Impact Considerations (Including Climate Change)

8.1 The environment and environmental impact considerations will be considered as part of the detailed work that results from the Sufficiency Assessment.

9. Equality Considerations

9.1 An Impact Assessment was prepared for the MPS in January 2020 and this still stands.

10 Risk Management Considerations

10.1 This Sufficiency Assessment is key to our risk management of care markets. For example, it helps us understand where clients may have difficulty receiving services because of a lack of good quality providers. We can then take mitigating actions to ensure that we maintain a sufficient marketplace. This has been particular important during the COVID19 situation.

11 Public Health Impact

11.1 The Public Health considerations will be considered as part of the separate work on the future plans contained in the action plan.

12 Summary/Conclusions/Reasons for Recommendations

12.1 The Market Position Statement, along with this Sufficiency Statement, are key tools for analysis our marketplace and delivering our plans, both countywide and at a local level. Without a vibrant market we cannot fulfil our statutory obligations, nor meet the changing needs of the public. Our providers are significant partners as well as contractors and we will continue to work with them to adapt the profile of supply and assist them with planning.

12.2 The impacts and uncertainties arising from Covid, added to the issues that were already present in our markets, will be a major challenge for some years to come.

Tim Golby
Associate Director of Commissioning (Care and Health)

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: Ian Hobbs/Tim Nand-Lal/Debbie Westlake
Tel No: 01392 382300

BACKGROUND PAPER	DATE	FILE REFERENCE

Market Sufficiency Actions 2020/21

Care Homes

Action	Activities	Impact	Timescale
Reassessment of demand profiles.	Review placement activity and analyse trends over past 6-12 months to inform demand profiles at locality level and in preparation for winter pressures. Link with systemwide CCG demand and capacity work to establish shared view of capacity and future demand requirements.	Demand understood resulting in an informed market development strategy and plan.	Middle of September 2020
Preparation of a Market Development Plan to address winter pressures and longer-term rebalancing of the market	Care home stratification to understand business critical homes. Develop market sufficiency dashboard to include close monitoring of vacancies and gaps in provision. Identify and support homes declaring high numbers of vacancies to maintain or address business viability. Provider assessment and development plan drafted and implemented.	Developed and supported market; any requirement for continued provider relief/support understood; capacity to support need maintained; barriers to admissions removed; provider failure averted.	Stratification / sufficiency dashboard complete early/mid September 2020 Market development plan – end of September 2020
Maintaining flow	Continuing the discharge to assess (D2A) and trusted assessor model as per the	Responsive, timely and	In train.

Action	Activities	Impact	Timescale
through the hospital system	government's 'Hospital Discharge Service: Policy and Operating Model, updated 21/08/20. Reviewing and where possible improving the Bed Bureau approach for hospital discharges. Maintaining and building market capacity to ensure sufficient supply on discharge.	prioritised discharges; capacity within the entire market utilised.	September 2020 for the new D2A arrangements.
Supporting on -going infection control measures	Action plan to support 'at risk' providers as identified via the DHSC infection control fund process. Continued Provider engagement and support via care home support meetings and webinars. Infection control support and training. Restore 2 training. C19 weekly huddle process to further identify and support at risk providers.	A supported market more able and equipped to prevent and/or manage infections and to promptly recognise and respond to any deterioration to the condition of residents.	On-going. The action plan to support providers is in train, to be completed ASAP. Infection control support and training – in train; planning for this to be an ongoing offer. Restore 2 training offer – October 2020 Infection control and provider risk datasets will continue to be monitored and providers supported as required.
Increasing capacity for people over 65 with complex mental health	Develop care pathway and local escalation plan for complex care placements.	Timely discharges from hospital for complex placements. Clear provider development	Pathway - September 2020 Market development –

Action	Activities	Impact	Timescale
needs	Task and finish group to work with care homes wanting to expand their current offer and develop different delivery models to support people with more complex mental health needs.	plan to increase market capacity for people over 65 with complex mental health needs.	September 2020 to December 2020
Reviewing capacity for people under 65 with complex need, physical disabilities and behaviour which challenge services.	Care home stratification to understand capacity and business critical homes for people under 65 with complex needs. Identify homes able to expand their current offer and support more complex people.	Understood market; clear fit for purpose development plan.	October / November 2020
Facilitating the Nursing Associate Apprenticeship Scheme, alongside other workforce initiatives in partnership with the NHS	Re-launch 2nd nursing associate programme for additional 10-15 candidates. Routine monitoring and responsiveness to the care home workforce data available on the Capacity Tracker. A more targeted proud to care approach to areas of market sufficiency and high turnaround of staff.	Improved recruitment in the sector, resulting in increased capacity.	On-going

Regulated (domiciliary) Personal Care

Action	**Activities**	**Impact**	**Timescale**
Increasing workforce capacity	Embedding improved Terms and Conditions	Improved recruitment and retention. Target to reduce awaiting care numbers.	Immediate, with reduction in awaiting care numbers by end march 2021

Action	Activities	Impact	Timescale
Reassessing demand profiles and preparing for winter	Understand new flow patterns through hospital discharge; Prepare winter plans	Revise demand pattern and help providers to adapt; Improve connectivity with our short-term offer; Localised plans and market action	Updated demand assessment by mid September; Winter Plans by end August; Local market strategies by end September
Continuing action to reduce the numbers of people waiting for care	Efficiency measures; whole system action	Better manage flow, review waiting list and seek alternative solutions; target localised solutions	Actions are already being taken and will be on-going
Building on our investment in the care workforce	Embed and monitor action to improve pay and conditions through contract variations	Strengthen the skill base, improve retention and boost recruitment	Contract variations embedded by end October
Phasing out agency staffing, subject to market response and needs over Winter.	Replace agency contract with new local market solutions	Reduce cost and redirect current investment into more sustainable local market solutions.	Agency phased out by end November
Planning for future arrangements for the Living Well At Home contract after July 2021	Initiate discussions with partners in context of local place-based commissioning	New model of delivery with potential for efficiencies	Initiate Autumn 2020. Complete by July 2021

Replacement Care

Action	Activities	Impact	Timescale
Invitation to providers to join a list of services offering replacement care	Development of list Streamlining of process	First countywide list, optimising potential and a basis for market development	Offer by 31 August 2020, operational from 31 October 2020
Market Development Plan to build resilience across Devon	Market analysis, provider engagement, service design and redesign	Improved capacity and choice and control for carers and cared-for persons	31 March 2021 (initial) 31 March 2022 (complete)
A focus on innovation, informed by the ideas and needs of unpaid carers	Needs analysis, survey of OLAs, option appraisal and market development	Increase supply and remodel existing options	31 March 2021 (initial) 31 March 2022 (complete)
Consideration of the potential for host family and live-in care	Use needs and market-analysis to build options appraisal	Potential new model of support	31 March 2021

Day Opportunities

Action	Activities	Impact	Timescale
Deliver financial and other support to day opportunities providers.	Risk assess all reopening plans, 1:1 with providers	Allows time for provider to safely re-open, adapt or close in a managed way	Through to 30th September 2020
Work with any providers under threat of closure	Open book exercise and support to rethink futures	Costed options allow lowest impact decisions to be understood and agreed	Resolve all provider plans by 30th September 2020
Pre-empt & identify emerging changes and challenges to the overall market at an early	Maintain fortnightly provider engagement discussion group	Quick responses to such issues as transport, PPE, restructures, & reduced capacity	Maintain until April 2021, then review.

Action	Activities	Impact	Timescale
enough stage to mitigate risks			
Work with Community Teams to address significant changes in client need and increased costs	Develop risk profiles for each team, and share/discuss with local managers	Plan operational team capacity to review service users and plan for local solutions	Maintain until April 2021, then review.
Opening the Supporting Independence framework (August 2020)	Invitation to new providers, and allow market price revision	Will allow existing market to reflect new post covid service costs and manage future sustainability	New prices take effect from 1 April 2021 until contract expiry at March 2022
Plan future commissioning arrangements from contract expiry at March 2022	Develop business cases and appraise options	Publish new commissioning intentions	Business case by October 2020

Supported living

Action	Activities	Impact	Timescale
Ensuring appropriate staffing levels, especially when staff work across various properties, to reduce risk of Covid transmission between settings	Implementation of the Infection Control grants enabling providers to manage staffing across their provision. Working with Proud to Care ensuring providers access support as required	Fewer COVID cases and other infections as well as improved staff retention	On-going

Enhancing training, technology and other support to mitigate infection control risks	Implementation of the Infection Control grants enabling providers to improve their IT capability. Implementation of our DCC TEC strategy New ways of working to make better use of technology and reduce the face to face meetings.	Improved mental health support, reducing hand-backs of clients with behaviours that challenge services and more effectively trained staff	Now and on-going
Developing specialist capability with providers to match crisis support needs, complex behaviour needs and transition support.	Housing with Support Development Project which includes the provision of support crisis in the housing pathway	Mitigates the risk of unplanned moves to different settings e.g. Care homes, Secure units and homelessness Provides therapeutic interventions to treat episodes of crisis and prevent increasing escalation	Now and on-going

Work with providers to: • prevent hospital re-admissions and support people leaving hospital • reduce the number of out of county placements • increase the number of providers taking new placements out of office hours • increase resilience and develop strong business continuity plans • to develop skills within their businesses to meet specialist needs including mental health, autism and complex needs	Implemented through a range of actions identified in the Housing with Support Development Project which align with Transforming Care objectives for system wide improvements	Reduction in in placement breakdowns, hospital admissions and out of county placements	Now and on-going
Work with District Councils and landlords to improve the supply of appropriate accommodation options.	Shared local intelligence to inform planning Define contractual (tenancy) arrangements Includes Extra Care Housing	Increased supply of housing matched to a range of needs Separates accommodation from care and support provision	On-going

Health and Social Care Overview and Scrutiny Committee
10 September 2020

Consultation Modernising health and care services in the Teignmouth and Dawlish area

Report of Torbay and South Devon NHS Foundation Trust and NHS Devon Clinical Commissioning Group

The Committee are asked to –

1. note the report and consultation plans in the context of a global pandemic;
2. use their role as community leaders to encourage wide engagement in the consultation process in the coastal communities affected.

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1. Executive Summary

1.1. NHS Devon Clinical Commissioning Group (CCG) launched its formal public consultation on future services in Teignmouth and Dawlish on the 1 September 2020. The consultation will end at midnight on 26 October.

1.2. The consultation was approved by the CCG's Governing Body in February 2020. It was due to launch in March 2020 but was postponed due to the COVID-19 pandemic. It has been kept under review since then.

1.3. The agreement reached for the purchase of the land for the new health and wellbeing centre between landowner, Teignbridge District Council, and purchaser, Torbay and South Devon NHS Foundation Trust, stipulated that work had to start on site in October 2020. The original consultation timeline was designed to enable this to be achieved. However, due to COVID-19, the timescale for the health and wellbeing development has been delayed and the start date has moved to January 2021.

1.4. The CCG remains committed to holding a transparent process and to keeping an open mind. A full copy of the consultation document is appended to this report.

2. The Consultation Process

2.1. A pre-consultation promotion of the process started on 18 August with stakeholders being able to visit the website to register as an interested stakeholder and receive regular updates, express an interest in attending an on-line meeting or to invite us to meet remotely with community group to discuss the proposal www.devonccg.nhs.uk/teignmouth-and-dawlish

2.2. The full consultation document has been made available on the CCG website[1], and paper copies are being distributed to every household in the

[1] www.devonccg.nhs.uk/teignmouth-and-dawlish
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Teignmouth, Dawlish, Bishopsteignton and Shaldon areas – **more than 16,000 homes**.

2.3. Along with the consultation document, the CCG has posted considerable supporting information on the dedicated section of its website, so that people can be well informed enough to come to a view on their response to the proposals.

2.4. The supporting information includes the clinical evidence for change, the strategic context, the evaluation of options, the impact of COVID-19, the engagement process, the impact on travel, finance, estates and the communication plan.

2.5. Healthwatch in Devon, Plymouth and Torbay is overseeing the consultation, and as of 1 September a free telephone number for feedback has been live[2].

2.6. A news release has been issued to the local media and posters are to be distributed to health and care premises and to post offices.

2.7. More than **133,000** leaflets are also being distributed in the Torbay and South Devon area where people might be affected by the proposals.

2.8. Because COVID-19 is still circulating, the CCG believes it would not be responsible for an NHS organisation to encourage people to take the risk of attending public gatherings and as a result this consultation will take place remotely.

2.9. However, there are many ways in which people can take part. They can:

- Fill in the detachable questionnaire in the consultation document and return it, free of charge
- Fill in the questionnaire online at www.devonccg.nhs.uk/teignmouth-and-dawlish
- Attend a live online meeting on any of the following dates, with the opportunity to express views and ask questions of a panel:

    - Friday, 11 September 2.30pm – 4pm
    - Thursday 17 September 10.30am -12noon
    - Wednesday 23 September 6pm -7.30pm
    - Tuesday 29 September 3pm – 4.30pm
    - Monday 5 October 11.30am – 1pm
    - Saturday 17 October 11am – 12.30pm

- Register at www.devonccg.nhs.uk/teignmouth-and-dawlish as an interested party, to receive updates as the consultation progresses
- Call the Healthwatch number 0800 0520 029 with any queries, to request further copies of the consultation document or to ask for a telephone call with an appropriate person from the CCG
- Ask for someone from the CCG to attend a remote meeting of their individual community group (with the CCG ready to use its Miscrosoft Teams platform to host this meeting if desired)

[2] 0800 0520 029

- Accept a CCG invitation to host a meeting (this offer being made to a wide range of community groups to ensure inclusivity)

3. The Proposal

3.1. NHS Devon CCG and the health community have worked with GPs, stakeholders and local people to develop a vision for health and wellbeing services in Teignmouth.

3.2. The potential of various options to achieve the vision have been assessed with a view to moving towards a proposal for public consultation. The proposal was approved by the CCG's Governing Body in February and the consultation originally scheduled for March 2020, but all plans were put on hold due to the COVID-19 pandemic.

3.3. The intention of Torbay and South Devon NHS Foundation Trust is to build an £8million modern Health and Wellbeing Centre in the heart of Teignmouth, with Brunswick Street as the preferred site.

3.4. This would enable Teignmouth's biggest GP practice, Channel View Medical Group, the health and wellbeing team, the voluntary sector, and potentially pharmacy to be co-located under one roof, working as one team to provide seamless care to patients and their carer or carers.

3.5. The centre would allow the safe flow of staff and patients around the building, enabling social distancing, and if necessary, the separation of suspected COVID-19 patients from non-COVID-19 areas.

3.6. Designated space for GPs to train new doctors would be available – which is not the case at present – and we would expect the current difficulties that GPs have in attracting new partner doctors to be eased because the new recruits would not be asked to take on liability for premises which fall below modern standards.

3.7. The single proposal, with four elements, is to:

a. Move the most frequently used community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre
   - This includes podiatry, physiotherapy and audiology. Because they are closely related to audiology, specialist ear nose and throat services would also move to the new centre
   - Overall, these clinics make up 73% of all the outpatient appointments currently held in Teignmouth, at the community hospital. And 91% of these clinics are used by local people, living within the Dawlish, Teignmouth and surrounding areas

b. Move specialist outpatient clinics, except ear nose and throat clinics, from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away
   - These are the specialist clinics, 23 in number, that are less frequently used at Teignmouth Community Hospital, making up only 27% of total appointments there

- They are currently used by people from all over South Devon and Torbay as well as those from Teignmouth and Dawlish. 70% of people using them come from outside the Dawlish and Teignmouth area

c. Move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital
   - This service includes minor procedures that require a specific treatment room
   - 86% of those using them come from outside the Dawlish and Teignmouth area, with more than half from Torbay
   - Journey times for many patients would increase, by up to four miles

d. Continue with a model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds at Teignmouth Community Hospital
   - After investment in community teams, we can now treat four times as many patients in their own homes as we could on a ward at Teignmouth Community Hospital
   - With the Nightingale Hospital established in Exeter, current analysis shows the 12 beds would not be needed for patients with COVID-19
   - The South West Clinical Senate, in a review, concluded that it was clear the 12 rehabilitation beds were not now needed
   - If the proposal is approved after consultation, Teignmouth Community Hospital would no longer be needed for NHS services by Torbay and South Devon NHS Foundation Trust, which would be likely to sell the building.

4. Why now?

4.1. Teignbridge District Council's full council approved a bid by the NHS to buy the site, subject to a number of conditions. One of these is that work on the Brunswick Street site must start in January 2021 to fit in with the wider regeneration plan for that part of the town

4.2. Devon Clinical Commissioning Group has now agreed with Channel View Medical Group in Teignmouth (with 17,966 patients) that it will relocate to the new centre. Teign Estuary Medical Group (with 4,611 patients) has at this stage not taken any decision to relocate

4.3. Formal approval was received from NHS England to proceed with a public consultation on the proposal to relocate – entirely within Dawlish and Teignmouth – the community clinics, specialist outpatient clinics and day case procedures currently provided within Teignmouth Community Hospital.

Electoral Divisions: Teignmouth, Dawlish, Ipplepen & the Kerswells and Kingsteignton & Teign Estuary.

Local Government Act 1972: List of Background Papers

Contact for Enquiries: d-ccg.teignmouthconsultation@nhs.net, go to the web site at www.devonccg.nhs.uk/teignmouth-and-dawlish or call Healthwatch on number 0800 0520 029

Background Paper	Date	File Reference
Modernising health and care services in the Teignmouth and Dawlish area	2 September 2020	

IMPORTANT:
NHS Public Consultation

1 September -
26 October 2020

NHS
Devon
Clinical Commissioning Group

Modernising health and care services in the Teignmouth and Dawlish area

Vision of the future - how the new Health and Wellbeing Centre for Teignmouth could look

Find out more about the NHS proposal and have YOUR say

Welcome

Our mission is to provide excellent integrated community health and care services in the Teignmouth and Dawlish area, and this document sets out some changes we would like to make to help us achieve it.

The NHS would like to build a new £8million Health and Wellbeing Centre in Brunswick Street, in the heart of Teignmouth, to house the town's biggest GP practice and other health and care services. A new, modern facility gives us a great opportunity to consider the best way to deliver other local services.

Having GPs, nurses, social workers, physiotherapists, other professionals and the voluntary sector working in a single setting opens up great new prospects for joined-up, seamless care.

Importantly, we believe it will ease the difficulties that GPs have had recruiting new doctors, many of whom are unwilling to take on liability and responsibility for surgery premises that are not good enough, either for staff or for patients.

Our formal proposal involves moving some less frequently used specialist outpatient services from Teignmouth to Dawlish, but no services currently being provided would be stopped, and all the services now provided in Teignmouth Community Hospital would stay in either Teignmouth or Dawlish. If the proposal is approved, Teignmouth Community Hospital would no longer be needed for NHS

Contents

You will find the pull-out questionnaire in the middle of this document

services and would be likely to be sold by Torbay and South Devon NHS Foundation Trust, to generate funds for reinvestment in the local NHS.

Part of our proposal describes moving community clinics – a set of outpatient services made up of audiology, physiotherapy and podiatry – to the new Health and Wellbeing Centre. Because of the link with audiology, ear nose and throat clinics would be co-sited. These are the clinics that are most frequently used by people in Teignmouth and Dawlish. We believe moving the community clinics to a modern building on a flat site in the centre of town, and under the same roof as other services, would be better for patients and staff.

Why now?

The COVID-19 pandemic has highlighted the importance of staff and patients being able to move safely round healthcare facilities. The new Health and Wellbeing Centre would allow us to meet this need.

The owner of the Brunswick Street site, Teignbridge District Council, has conditionally agreed to sell the land to the NHS. As part of this agreement, work has to start on site in January 2021, to fit in with the overall regeneration of that part of the town.

Our proposal

a) Move high-use community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre in Teignmouth.

b) Move specialist outpatient clinics from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away.

c) Move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital.

d) Continue with the model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds in Teignmouth Community Hospital.

We are therefore holding this consultation to find out what local people think, before we decide whether the community clinics should move to the new building.

A new approach to consultation

Because of COVID-19, we have adapted our approach to ensure people can express their views but in a safe manner. Our materials are being sent to many thousands of homes in Teignmouth, Dawlish and beyond. You can see at the end of this document that we will also be holding live meetings, online.

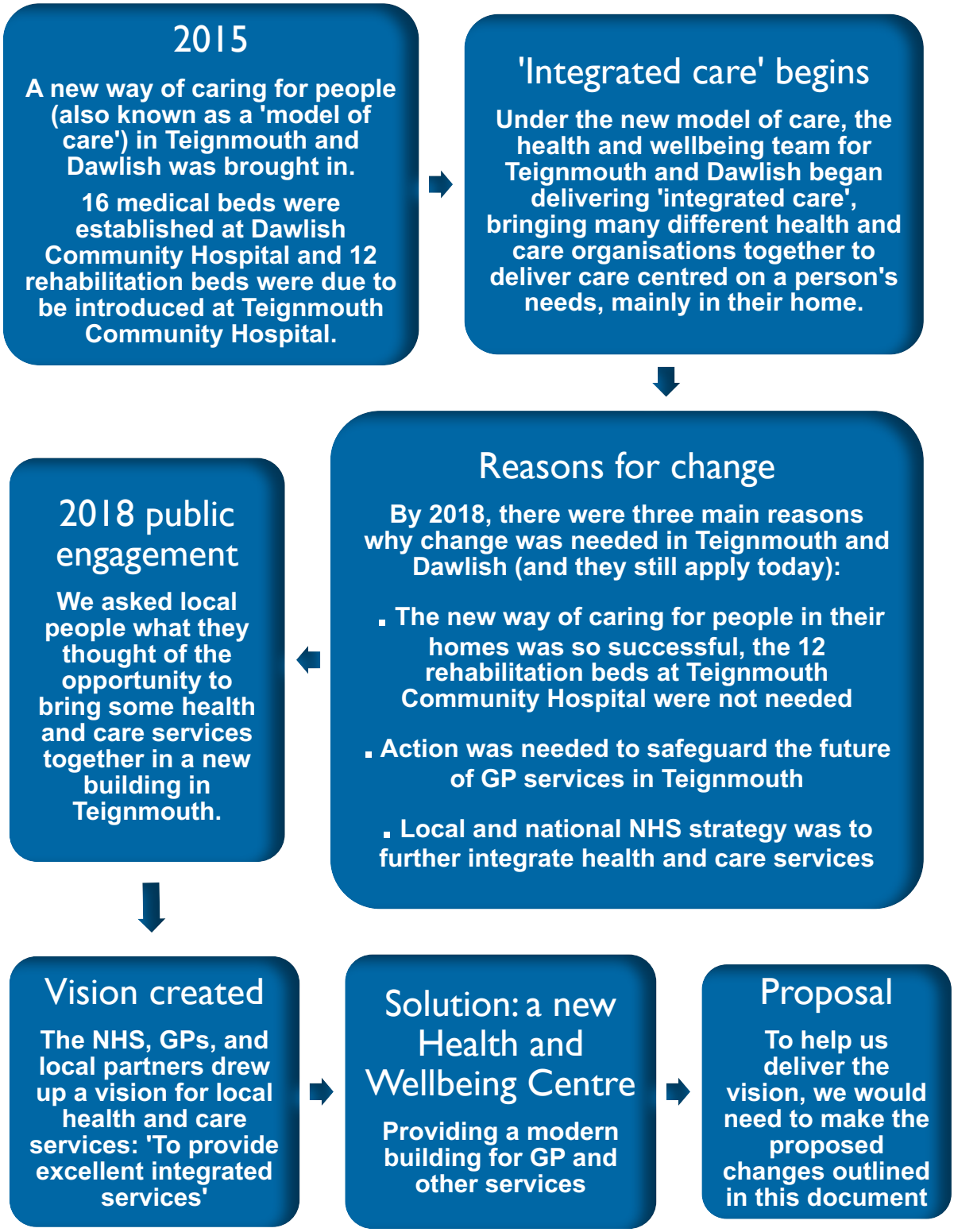
Our independent partners, Healthwatch in Devon, Plymouth and Torbay will be overseeing this consultation, and evaluating your responses.

Thank you for taking the time to read this document. We believe our proposals are well thought out. However, for the eight weeks of the consultation we will be listening carefully to your insights, views and ideas. So it is now over to you.
We look forward to hearing from you.

Dr Paul Johnson
Clinical Chair
NHS Devon Clinical Commissioning Group

Essential summary

This page provides an overview of what's in this consultation document, showing how we reached our proposal for change.



Background – how local people have shaped our proposal

The proposal has been directly shaped by the views of local people and is the latest step in a long period of talking to people in Teignmouth and Dawlish about what is important to them.

Here we summarise the consultation and engagement that has happened with local people in recent years.

2013 – A public engagement programme in South Devon and Torbay asked people what was important to them in terms of health and care services. These discussions were held in towns and villages across the area. The importance of good access to services, the role of carers, good communication between clinicians and patients, consistency, support to stay at home and good co-ordination between services were among the key outcomes.

2014/15 – A formal public consultation process was held in Teignmouth and Dawlish on the future of health services in the locality.
In March 2015, the Governing Body of South Devon and Torbay Clinical Commissioning Group(CCG) agreed to implement the proposals.

2016 – A further public consultation was held in the rest of South Devon and Torbay. The emphasis was on the integration of services and implementation of a new model of care based on care as close to home as possible. This led to the model of care that we now have across our area, including in Teignmouth and Dawlish.

May 2017 – Due to the success of the new model of care introduced in the Teignmouth and Dawlish area from 2015, South Devon and Torbay CCG agreed to review the need for the 12 rehabilitation beds that were due to be implemented as part of the outcome of the 2014/15 consultation.

April to June 2018 – South Devon and Torbay CCG ran a public engagement programme with representatives of local organisations, including Torbay and South Devon NHS Foundation Trust, local Leagues of Friends groups, GPs and Patient Participation Groups, asking what local people thought of the opportunity to bring some health and care services together in a new building in Teignmouth.
The outcomes helped shape the vision for local health and care services.

1 September to 26 October 2020– Building on what people have told us over the years, and responding to a need to change, we are now putting forward our proposal for formal public consultation. Local people were involved in helping us choose the options for consideration and evaluating them.

What services do we have now?

In Teignmouth and Dawlish, the many different parts of the health and care system have developed a way of working together in a joined-up way to provide “integrated care”.

The aim is to make sure that all the people in the health and care system who are looking after someone work together as one team to support them, instead of passing a patient on from one service to another. All parts of the system have the relevant information about someone’s situation, so they don’t have to repeat themselves. Another key aim is to make sure people get help promptly so their situation does not escalate into a crisis.

Who provides the care and how does it work?

Health and wellbeing team

The team meets daily to plan the care of people who are most at risk of deteriorating to the point of needing a hospital stay. People in Torbay Hospital or a community hospital bed are also discussed to see how they can be discharged as soon as possible in a planned, safe and supported way. The team includes: GPs, community matron, community nurses, occupational therapists, physiotherapists, social workers, social care assessors, pharmacists, NHS clinical support workers (like health care assistants and assistant practitioners) and support workers from local charity Volunteering in Health to help link people to their communities.

Intermediate care

This service supports people coming out from hospital, prevents people from being admitted unnecessarily and provides rehabilitation for those recovering from injury or illness. The team visits people at home to support them and uses short term placements in local residential or nursing homes when someone is unable to remain at home due to illness or injury but does not require hospital admission.

Rapid response

Providing care visits for someone who may be in crisis at home.

Teignmouth Community Hospital

A base for:

- Community clinics (which make up 73% of outpatient appointments): audiology, physiotherapy, podiatry
- Day case procedures (minor procedures that require a specific treatment room)
- Specialist outpatient clinics (making up 27% of outpatient appointments)

Dawlish Community Hospital

- 16 medical beds – for more acutely ill and complex patients
- Minor Injury Unit
- Outpatient clinics – more than 20 types of service from abdominal aortic screening to X-ray

Social care reablement

Short-term care support (up to four weeks) with a focus on rehabilitation.

Night sit

Used to support people who need regular overnight support due to a short-term crisis.

Domiciliary care support

Means-tested longer term support provided by private agencies.

Four main reasons why we need to change

<u>Reason for change 1</u> – evidence shows the joined-up way we care for people is so effective in keeping them at home and out of hospital that we don't need the 12 rehabilitation beds that were planned for Teignmouth Community Hospital.

The way care is provided – known as the 'model of care' – in Teignmouth and Dawlish is very successful.

In fact, it has been showcased nationally and internationally.

The model of care sees GPs, community health and social care teams and the voluntary sector working together to provide for the vast majority of people's health and wellbeing needs in the area in which they live.

They have demonstrated that intermediate care can provide the rehabilitation needed in people's homes, in short residential placements or occasionally in Dawlish Community Hospital.

We estimate that about 300 people, with this care, have avoided admission to Torbay Hospital. We can now treat four times as many people in their own homes as we could in a rehabilitation ward in Teignmouth Community Hospital with the same investment.

Successfully reducing the need for bed-based care

Researchers from the University of Plymouth have been studying how well the current way of caring for people in Teignmouth and Dawlish is working – and their findings indicate it is working very successfully.

Their findings include:

- The Teignmouth and Dawlish area has a much lower proportion of over-70s needing some form of bed-based care than other parts of South Devon and Torbay. Researchers believe this could be because the intermediate care team in the Teignmouth and Dawlish area can manage more complex cases at a community level, often in people's homes, without the need to use any type of bed-based care
- A higher proportion of over-70s in the Teignmouth and Dawlish area receive bed-based care in their own bed compared with other areas, thanks to the way care is provided in the area. This way of caring for people would have to change if staff were diverted to running a bedded rehabilitation ward in Teignmouth Community Hospital

- The proportion of over-70s in the Teignmouth and Dawlish area who have to use an emergency hospital bed is much lower compared with other areas

Read more about the research online at www.devonccg.nhs.uk/teignmouth-and-dawlish

The NHS England South West Clinical Senate, a panel of independent expert clinicians, reviewed the model of care that was in place across South Devon and Torbay (including Teignmouth and Dawlish) in 2016. Members of the original 2016 clinical panel were subsequently convened in 2019 to undertake a further review of emerging proposals for changes to services in the Teignmouth and Dawlish area. The panel gave formal answers to a series of questions, including the following:

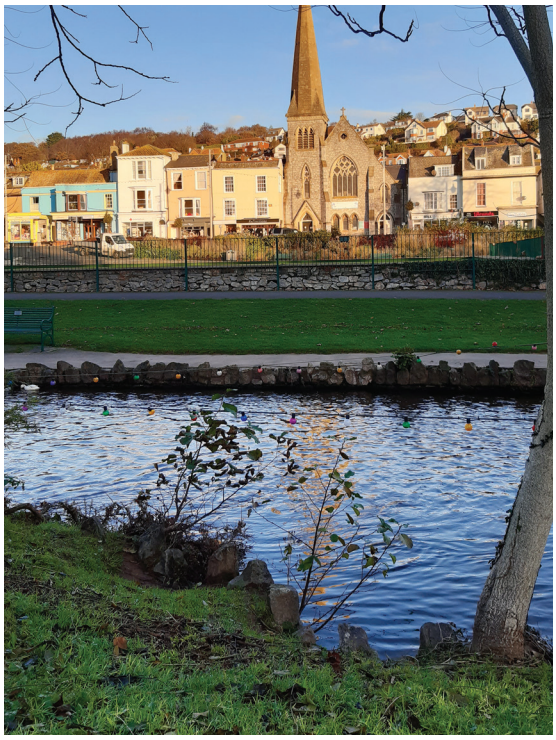
Can the Clinical Senate be assured that the 12 new rehabilitation beds originally proposed in the 2015 Consultation (which it did not input into at the time) are no longer required?

Answer: It seems very clear that they do not need the 12 rehabilitation beds that were proposed for Teignmouth hospital in 2015, but which have never been implemented. The impact of the Integrated Care Team has reduced the need for beds despite the demographic and demand.

Can the Clinical Senate confirm that the relocation of services out of Teignmouth Community Hospital does not constitute a change in Service Model?

Answer: The Clinical Senate is satisfied that the relocation of services out of the hospital does not constitute a change in the service model. There is a change to the proposed service model that was originally consulted on as regards to the rehabilitation beds however these were never operational due to the success of the Enhanced Intermediate Care Team and therefore the actual service model is not being significantly changed.

Overall it is a variation in service capacity and location with reasonable justification.



Reason for change 2 – safeguarding the future of GP services

GPs from Teignmouth's biggest practice, Channel View Medical Group, would like to co-locate their services with community services and Volunteering in Health. This will further integrate primary care – all those services provided by the surgery – with other community services for patients and carers. Sharing the new building will provide greater scope for flexible responses, team development, and sharing of some administrative functions.

Change is needed for GP services to be fit for purpose, sustainable into the future and flexible to meet the changing needs of the population. There are a number of current issues for GPs in Teignmouth, who want to develop new ways of working and be able to take advantage of the expansion in the workforce such as pharmacists and social prescribers.

1. Current surgery buildings are not fit for purpose. The GP buildings are old residential buildings, converted years ago. They are cramped with no further scope for expansion and have limited access, especially for disabled people. The 2018 engagement exercise showed people supported co-location and wanted their GP practice to be on a flat site, in the centre of town, easily accessible by public transport.

2. Recruiting new GPs. This is a countrywide issue. GPs need to be attracted to work in this area at a time when fewer GPs are willing to become partners who lead and develop GP practices. Some are further discouraged by the commitment and liability of owning buildings at the beginning of their careers, when they might already have sizeable student loans and their own private mortgage. Working from a modern purpose-built health and wellbeing centre, which is leased, would make Teignmouth a more attractive option for new GPs.

3. The constrained space limits the scope to teach and train medical students and trainee GPs and nurses.

4. The need to be flexible and adapt to meet future needs of the population. How working patterns have had to change in response to the COVID-19 pandemic is only one example of this.

> ***'We also need to increase the flexibility of facilities to accommodate multi-disciplinary teams and their training, innovations in care for patients and the increasing use of technology. And new premises may be needed to cater for significant population growth, and to facilitate primary care at scale or enable patient access to a wider range of services.'***
>
> NHS England's GP Forward View

A doctor's view

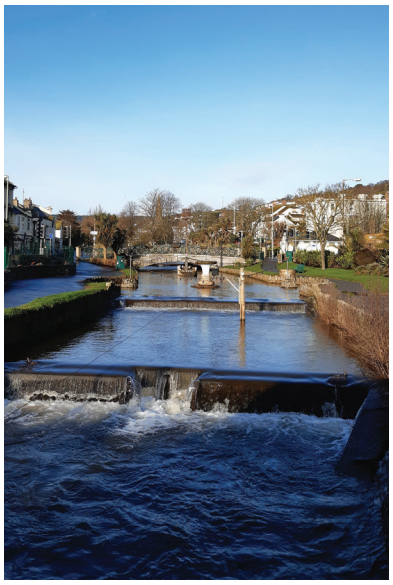
Dr Carlie Karakusevic, of Channel View Medical Group, explains why moving to a new Health and Wellbeing Centre is vital to the future of GP Services in Teignmouth.

When I first came to work in Teignmouth more than 25 years ago, the landscape of General Practice was very different. There were six practices in the town, all working in isolation. At that time a patient with diabetes, for example, would have had most of their care in a hospital clinic. Over time, new ways of working have developed. Now, a diabetic patient will have regular reviews in the GP practice supported by GPs and practice nurses trained to provide this care.

In April 2020, Channel View Surgery and Teignmouth Medical Group merged to form Channel View Medical Group. Teign Estuary Medical Group is an independent practice. We work very well together as part of the Coastal Primary Care Network, sharing resources and expertise.

Like every local GP, I have got to know my patients over the years and I love working in Teignmouth. It's a vocational profession and I get huge pleasure from my work. It is a privilege to develop relationships in the town over a long period of time.

The new Health and Wellbeing Centre would play a key role in safeguarding the future of GP care in Teignmouth. I would wholeheartedly encourage the town to support this vision for Teignmouth.



Reason for change 3 – making the most of the local community hospital estate

Teignmouth Community Hospital

was opened 66 years ago, in 1954. We believe the hospital cannot be economically reconfigured to provide the modern facilities required today and in the future.

During the 2018 public engagement (see page 5) the issues of limited parking and the hospital's location up a steep hill on the edge of town were highlighted. Support for a new centre for many was conditional on finding a flat site, which people can access by car, public transport or on foot. And most respondents thought that a town centre site was the best option.

A six-facet survey, dated 30 November 2018, was carried out by independent surveyors and was commissioned by Torbay and South Devon NHS Foundation Trust (TSDFT).

The six-facet survey considers physical condition (by visual inspection), functional suitability, use of space, quality, statutory requirements and environmental management.

A summary of the survey:

- Approximately £604,400 (inclusive of VAT) would need to be spent to bring the building up to required standards in the short term
- An additional £960,000 (inclusive of VAT) would be needed between now and 2022 to address building issues
- The physical condition of the building was found to be sound, operationally safe and exhibits only minor deterioration
- The hospital itself was found to be a 'less than acceptable' facility for people using the building, requiring significant capital investment
- Fire and Health and Safety assessment showed the building to be below the required statutory standard
- The space is underutilised – this relates to the current empty ward area. CCG/TSDFT note: While the current space is underutilised, it would not be sufficient to meet the requirements of a modern health and wellbeing centre with primary care
- The building contains asbestos
- The environmental impact of the building is high, it is not energy efficient and would require significant investment to bring it to standard

> ***'We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services.'***
>
> NHS Long Term Plan

Dawlish Community Hospital

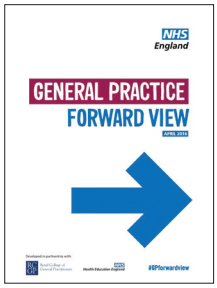
is a modern, purpose-built hospital with space and capacity that can be better used. It is about four miles from Teignmouth and is easily accessible including by public transport.

Reason for change 4 – delivering national and local plans and strategy for health and care that emphasise the need for further integration of health and care services

Among the aims of the **NHS Long Term Plan** are:

- bringing together different professionals to coordinate care better
- helping more people to live independently at home for longer
- developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home
- upgrading NHS support to people living in care homes
- giving people more control over their own health and the care they receive
- encouraging more collaboration among GPs, their teams and community services to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners
- planning and delivering services which meet the needs of their communities
- training and employing more professionals and making the NHS a better place to work
- getting the most out of taxpayers' investment in the NHS
- accelerating estates transformation and making best use of the NHS estate

The **NHS GP Forward View** includes a focus on investing in improving GP buildings to improve services for patients and enable a wider range of health services closer to where they live.



Our **Devon integrated care model** outlines how organisations work together in your local community, bringing together GPs, mental health, social care and community services to meet people's needs.

The key elements of the model are to:

- Work proactively together to make sure that people are linked into services that will support them to live as independently as possible at home
- Ensure individuals and their carers have easy and ready access to information about local services and that they are supported to navigate these options and make informed decisions about their care
- Support organisations working together to develop services and deliver care that meets the needs of individuals living in the community
- Make sure that people can easily access services for urgent health and social care needs
- Ensure providers and practitioners have ready access to the information they need and share information appropriately

The vision

Our vision for health and care services in Teignmouth and Dawlish:

'To provide excellent integrated services'

- **To build on the success so far of integrating services**
- **To ensure the sustainability of primary care in Teignmouth**
- **To help people stay well and support them when they need help**
- **To enable people to stay at home for as long as possible**

What are 'integrated services?'

For health, care and support to be 'integrated', it means moving away from short periods of care provided by one service in isolation, towards an approach that focuses on the whole person, taking into account mental and social factors, rather than just the symptoms of an illness.

It means that care for each person and/or their carer is joined up and well connected with good communication, even when that care is provided by a number of different organisations, such as mental health, social care, GPs or NHS health services. It puts the needs of each person at the centre of how their care is organised.

Where did the vision come from?

The vision has been developed by local NHS partners, including GPs, commissioners and Torbay and South Devon NHS Foundation Trust. Developing integrated care is a key aim of the **NHS Long Term Plan**, and the emerging Devon Long Term Plan, called Better for Devon, Better for You, produced by the Devon **Sustainability and Transformation Partnership (STP)**, a partnership of NHS and local authority partners. The STP has recently been given a new identity, and is now known as Together for Devon.

Together for Devon

Health and care working in partnership with local communities in Plymouth, Torbay and the rest of the county

'Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and Allied Health Professionals such as physiotherapists and podiatrists/ chiropodists, joined by social care and the voluntary sector.'

NHS Long Term Plan

Our solution – a new Health and Wellbeing Centre for Teignmouth

An £8million centre in the heart of Teignmouth for integrated GP and other health and care services

How the new Health and Wellbeing Centre in Teignmouth could look

There would be lots of benefits to a new Health and Wellbeing Centre. (This of course would be subject to the usual planning consents.) Apart from meeting environmental standards and being energy-efficient, it would offer:

Improved training opportunities – It would offer better opportunities to train new GPs and other clinical staff. This would mean better professional development for senior staff and improved opportunities to encourage new GPs and nurses to work in Teignmouth in the long term.

Working under the same roof as other health and care colleagues – Conveniently being in the same building, providing 'integrated care', with fellow health and care organisations benefits staff and patients. Greater integration between teams improves our ability to support people in their own homes, further reducing hospital admissions and demand on Torbay Hospital.

Great place to work – Working in a bright, modern and airy environment is much more attractive. The new Health and Wellbeing Centre in Teignmouth would be built to today's standards, to

the right specification, and with easier access for patients and carers, especially those with disabilities.

More space so other services can be included on a drop-in basis such as housing and mental health.

Attracting new GPs is key to safeguarding the future of GP services in Teignmouth and moving GP services to a modern, fit-for-purpose centre would help make Teignmouth's GP services sustainable in the long term.

As well as benefitting from the other advantages on this page, prospective GP partners are much more likely to take on a partnership in a leased and purpose-built facility because there would be no burden of property ownership. Torbay and South Devon NHS Foundation Trust would hold a head lease on the Health and Wellbeing Centre and would sub-let to the GP practice. The practice's rental costs would be paid by Devon CCG, in line with normal national funding procedures for GP premises.

What would be in the Health and Wellbeing Centre?

Channel View Medical Group

The newly-merged practice would relocate from its sites in Courtney Place and The Den. Channel View Medical Group has 17,966 patients on its list.*

Teign Estuary Medical Group, at Carlton Place (sometimes known as Glendevon), which has 4,611 patients on its list, has at this stage not opted to relocate to the new centre.

The health and wellbeing team

of community nurses, therapists and social workers - see page 6.

Volunteering in Health

Being located in the same building as GPs and other community-based health and care services would further strengthen links between the NHS and the voluntary sector.

Pharmacy

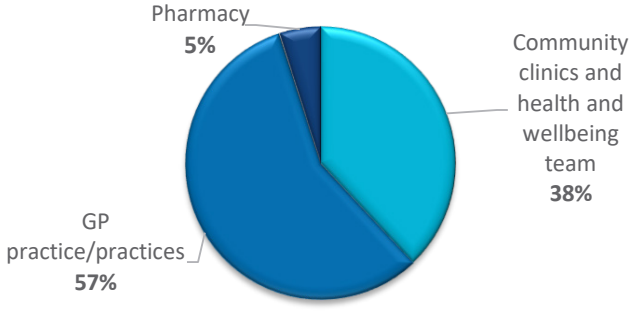
Torbay and South Devon Foundation Trust is seeking a local pharmacy to move to the Health and Wellbeing Centre, subject to approval by NHS England.

Other services could also be located in the building, depending on the outcome of this consultation process and the decisions that will follow it.

Delivering the new centre

Torbay and South Devon NHS Foundation Trust, which provides the community services in the town, has developed plans for what the building could look like (subject to planning consents) and how it could be used. Its suggestions for how it is used form part of this consultation.

How would space be allocated in the new building if our proposal were approved?



(subject to consultation)

*It should be noted that GPs from Channel View practice in Teignmouth will hold their own discussions with patients about a move to the new Health and Wellbeing Centre in the town centre.

The impact of COVID-19

The COVID-19 pandemic has meant that the health and social care system has had to deliver services in different ways, and this is being taken into account in our planning for the future.

This includes detailed planning for a potential second wave, and longer-term changes to the way services are provided.

Digital technology has been crucial in enabling patients to access their GP and primary care services in a safe way. In the Coastal area, more than 2,000 online consultations took place between 2 March and 2 August, with a steady increase over this time. Almost 500 video consultations took place. Patients will still be seen face to face by their doctor or clinician, but in smaller numbers than before.

The new Health and Wellbeing Centre will have up to date digital technology, allowing this new model of primary care to continue. In addition, the centre is being designed to allow for social distancing and the safe flow of staff and patients.

Our modelling shows that, with NHS Nightingale Hospital Exeter in place, there is adequate capacity for caring for people with COVID-19 without the need to use the beds or space at Teignmouth Community Hospital.

From April 2020 to 1 July 2020, 1,120 people were discharged from Torbay Hospital needing some kind of additional support. Of these, more than three quarters were able to return straight home with a support package in place and 8% needed a short term placement in a care home. Throughout this period, GPs across Dawlish and Teignmouth worked with the community team to provide comprehensive support to the care homes so that these patients were cared for in the best possible way. This careful response has set a strong foundation on which local teams are now in the process of building.

The community team has also supported care homes with the management of any possible outbreaks, as well as with testing for COVID-19.

Our proposal for consultation

Our vision is to provide excellent services that work seamlessly together. Our proposal helps us achieve that and would also allow us to build on the successful way local people are cared for in their own homes.

This proposal has three main benefits:

1. It helps us deliver the next phase of our vision of excellent integrated health and care services in Teignmouth and Dawlish.
2. It addresses the Reasons for Change section.
3. It supports the creation of a new, purpose-built Health and Wellbeing Centre in Teignmouth.

This proposal has four elements (listed a-d), as detailed in the box to the right.

We recognise that Teignmouth Community Hospital has served local people well over the past decades and many people do not want to see the building close.

If the four elements of the proposal were approved, services would move to modern, purpose-built centres which would serve future generations of local people. This would mean the community hospital would no longer be needed by the NHS.

If the proposal is approved, Teignmouth Community Hospital would no longer be needed for NHS services and would be likely to be sold to generate funds for reinvestment in the NHS.

We know that parking in Teignmouth town centre can be difficult, but it is not always easy at Teignmouth Community Hospital, either. The town centre does, however, benefit from good public transport.

Our proposal

a) Move high-use community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre in Teignmouth.

b) Move specialist outpatient clinics from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away.

c) Move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital.

d) Continue with the model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds in Teignmouth Community Hospital.

On the following pages, we consider each element in more detail and explain the other options considered and why they were discarded.

a) Move high-use community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre in Teignmouth

The community clinics are the outpatient clinics used most by local people and the proposal is to keep them in Teignmouth at the new Health and Wellbeing Centre in an accessible location.

The hospital is currently a base for a range of outpatient clinics and people from across South Devon and Torbay can choose to have their appointments there.
There are two main types –

- Community clinics
- Specialist outpatient clinics

(see page 20).

The community clinics are: audiology, physiotherapy and podiatry. Most people who use these community clinics are from the Dawlish and Teignmouth area.
We are also proposing to move ear nose and throat outpatient appointments to the new Health and Wellbeing Centre as they are closely related to the audiology clinics.

The table below uses data from Torbay and South Devon NHS Foundation Trust to illustrate the number of community clinic appointments, and ear nose and throat appointments per month. Under our proposal, these would all stay in Teignmouth but be moved to the new Health and Wellbeing Centre in the town centre.

Overall, these community clinics make up about three quarters (73%) of all outpatient appointments currently held at Teignmouth Community Hospital.

Community clinic	Average number of appointments per month (July 2018 to June 2019)
Audiology	177
Physiotherapy	1,029
Podiatry	158
Total	**1,364**

Where people using the clinics live	%
Coastal (Teignmouth and Dawlish)	91%
Newton Abbot	4%
Moor to Sea (Ashburton, Buckfastleigh, Totnes and Dartmouth, Chillington)	1%
Torbay	4%

Of the 91% of people using these clinics who live within the Teignmouth and Dawlish area:

- **9%** of people came from the Shaldon/Stokenteignhead direction on the other side of the estuary. If the clinics were moved to the new Health and Wellbeing Centre in the town centre, patients would need to travel slightly further into town if they came by road
- **23%** come from an area stretching west and north from Teignmouth Community Hospital, including Bishopsteignton. They would have to travel an extra mile into Teignmouth town centre
- **24%** live in Teignmouth, and most would be nearer to the town centre where the new Health and Wellbeing Centre would be than the existing hospital. They are likely to find it easier to get to the town centre than to the current hospital location
- **13%** live north or east of the hospital and closer to the hospital than the town centre. They would have to travel slightly further to get to the town centre
- **39%** come from the area between Teignmouth and Dawlish or the Dawlish area. These people would not have any further to travel if their appointment was moved from Teignmouth Community Hospital to the town centre and public transport would be easier

Options considered for community clinics

Three sites were considered as possible locations for high use clinics - **the new Health and Wellbeing Centre**, the existing **Teignmouth Community Hospital** and a **new facility on the site of Teignmouth Community Hospital.**

It is proposed to move these clinics to the Health and Wellbeing Centre because:

- Basing them with GPs, the health and wellbeing team and voluntary sector would create a community facility, making good use of the rooms
- It would help staff from different teams to work together to further develop integrated care
- Teignmouth Community Hospital is not sustainable as a health facility
- A new-build on the site of Teignmouth Community Hospital is not as cost effective as locating the clinics at the Health and Wellbeing Centre

a) Summary

Now

- **High use community clinics - audiology, physiotherapy, podiatry - are located at Teignmouth Community Hospital**

Proposed change

- **Move the clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre**

After

- **The same high use community clinics - audiology, physiotherapy, podiatry - would be provided at the new Teignmouth Health and Wellbeing Centre**

b) Move specialist outpatient clinics, except ear nose and throat clinics, from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away

These appointments are less likely to need regular attendance. They are also provided to patients from all over South Devon and Torbay.

The proposal therefore is to move specialist outpatient clinics (except for ear, nose and throat clinics which need to be based alongside the audiology clinic and therefore would move to the new Health and Wellbeing Centre in Teignmouth) four miles to Dawlish Community Hospital. The specialist outpatient clinics, which are less frequently used by local people than community clinics (see page 13-14), are:

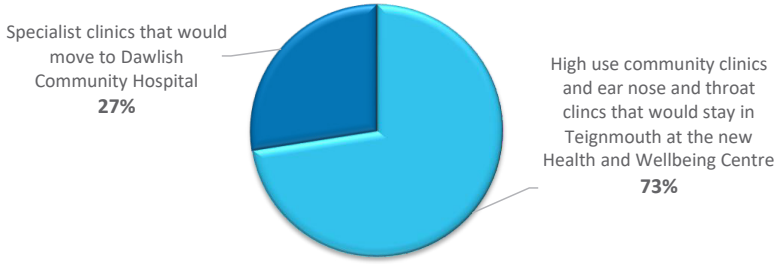
- Abdominal aortic screening
- Anaesthetics
- Breast
- Cardiology
- Chronic fatigue/ME
- Clinical psychology
- Colorectal
- Dermatology
- Ear, nose and throat
- Genetics
- Gynaecology
- Neurology
- Oral outpatients
- Orthopaedics
- Orthoptist
- Pain management
- Paediatrics
- Parkinson's
- Plastics
- Retinal screening
- Rheumatology
- Upper gastro-intestinal
- Urology

These clinics are currently used by people from Dawlish, Teignmouth and all over South Devon and Torbay. Although moving them would mean people from Teignmouth would need to travel the short distance to Dawlish, it would make access easier for people in Dawlish, and for people coming from elsewhere the difference would be minimal.

The clinics that would move make up only 27% of outpatient appointments at Teignmouth Community Hospital

Although there are several different types of specialist outpatient clinic listed above, they make up only about a quarter **(27%)** of the outpatient appointments at Teignmouth Community Hospital. The vast majority of appointments – **the other 73%** – are for the **community clinics** detailed in **element a)** of our proposal on page 18 and which would **stay in Teignmouth** at the new Health and Wellbeing Centre in the middle of town.

The pie chart uses data provided by Torbay and South Devon NHS Foundation Trust from July 2018 to June 2019



Where do the people using the specialist outpatient clinics live?

Locality / Area	%
Coastal (Teignmouth and Dawlish)	30%
Newton Abbot	24%
Moor to Sea (Ashburton, Buckfastleigh, Totnes and Dartmouth, Chillington)	8%
Torbay	38%

30% of people using these clinics live in the Teignmouth and Dawlish area. Of these:

- **8%** of patients would need to travel further from Shaldon/Stokenteignhead direction on the other side of the estuary, and would need to go further to get to Dawlish
- **3%** come from the Bishopsteignton area and would be likely to drive 4 miles further to Dawlish
- **4%** come from a large rural area north west of Teignmouth Community Hospital and would have to travel slightly further to get to Dawlish. If travelling by car, they would be likely to take a more direct route, reducing the extra distance travelled
- **32%** travel from north east of Teignmouth Community Hospital, which would mean their journey would increase from around a mile to about four miles or less
- **35%** would have a shorter journey to get to Dawlish Community Hospital, compared with getting to Teignmouth Community Hospital

Options considered for specialist outpatient clinics and day case procedures (see also page 19-20)

Dawlish Community Hospital, the existing Teignmouth Community Hospital, a new facility at Teignmouth Community Hospital, Newton Abbot Community Hospital and Torbay Hospital were considered as sites for the more specialist outpatient clinics and day surgery services.

It is proposed to move these services to Dawlish Community Hospital because:

- Basing these in a specialist centre in the locality means they would be supported by experienced, skilled medical staff and in the same building with medical beds
- Public engagement with people in Teignmouth and Dawlish in 2018 showed people wanted to keep these within the locality
- Newton Abbot and Torbay do not have capacity to provide these services and are not in the Dawlish and Teignmouth area
- Teignmouth Community Hospital is not a sustainable option in the future
- A new-build on the site of Teignmouth Community Hospital is not as cost effective as locating the clinics at Dawlish Community Hospital

b) Summary

Now

- **Specialist outpatient clinics are located at Teignmouth Community Hospital**

Proposed change

- **Move specialist outpatient clinics to Dawlish Community Hospital, four miles away, except ear, nose and throat clinics which would move to the new Health and Wellbeing Centre in Teignmouth**

After

- **Specialist outpatient clinics would be located at Dawlish Community Hospital**
- **Ear, nose and throat clinic would be provided at the Health and Wellbeing Centre**

c) Move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital

This service includes minor procedures that require a specific treatment room. They include oral surgery with an average of 20 attendances per month, pain management with an average of nine, and plastic surgery with an average of 70 attendances per month. People come from across the South Devon and Torbay area to attend these appointments. The proposal is to move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital.
Options considered: see the box above on page 22.

Where do the people using the day case procedures live?

Locality / Area	%
Coastal (Teignmouth and Dawlish)	14%
Newton Abbot and Moor to Sea (Ashburton, Buckfastleigh, Totnes and Dartmouth, Chillington)	35%
Torbay	51%

This means about 86% of patients will have to travel four miles further for their appointments. These people are likely to be travelling by car or public transport.
Of the 14% of people who live in the Teignmouth and Dawlish (Coastal) area:

- **21%** would need to travel further from Shaldon/Stokenteignhead direction
- **8%** come from the Bishopsteignton area and would be likely to travel four miles further to Dawlish Community Hospital
- **6%** come from a large rural area north west of Teignmouth Community Hospital and would have to travel slightly more to get to Dawlish Community Hospital. If travelling by car, they would be likely to take a more direct route, reducing the extra distance travelled
- **26%** come from north east of Teignmouth Community Hospital, making their journey increase from around a mile to four miles or less
- **23%** would have a shorter journey to get to Dawlish Community Hospital compared to getting to Teignmouth Community Hospital

c) Summary

Now
- **Day case procedures take place at Teignmouth Community Hospital**

Proposed change
- **Move the day case procedures to Dawlish Community Hospital four miles away**

After
- **Day case procedures would take place at Dawlish Community Hospital**

d) Continue with a model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds in Teignmouth Community Hospital

Since the changes implemented following the consultation in 2014/15, our overarching goal has been to support people in their own homes and avoid people being admitted to hospital when more appropriate care can be provided to them at home.

By investing in our community services, and by working in partnership with our local GPs and the voluntary sector, we have significantly reduced the need for people in our area to be admitted to hospital, as detailed on pages 11 to 13 above.

We know when people are in their own familiar home environment, they have the best chance of keeping mobile and active for as long as possible. This is particularly important for those with dementia as we know it can be very distressing to them to be in a strange hospital environment.

We can now treat four times as many patients in their own homes as we could in a rehabilitation ward in Teignmouth Community Hospital with the same investment.

The success of this way of working has meant that the proposed rehabilitation beds have not been required at Teignmouth Community Hospital over the past two years and we do not envisage them being needed in future.

If the beds were to be opened, we would need to reduce some of the community-based services which are working well to fund and staff them and we don't believe this is in the interests of the people of Teignmouth and Dawlish. See also the panel on options considered on page 25.

The South West Clinical Senate reviewed the South Devon and Torbay model of care in 2016 and members of the original 2016 clinical panel undertook a review in early 2019 to consider the clinical evidence for proposals to change services in Teignmouth and Dawlish. The Clinical Senate concluded that:

- The model being used for Teignmouth and the Coastal locality is largely the same as that used for the other localities within South Devon
- It seems very clear that the 12 rehabilitation beds that were proposed in 2015, but which have never been implemented, are not needed
- The Clinical Senate is satisfied that the relocation of services is a variation in service capacity and location with reasonable justification

Options considered for the 12 rehabilitation beds

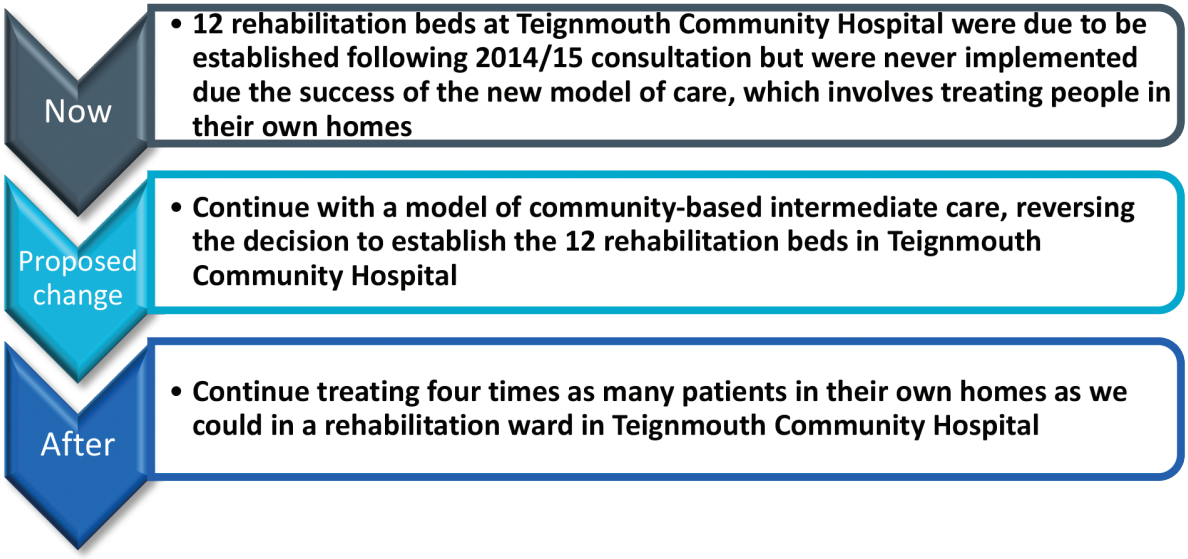
Two options were considered for the 12 rehabilitation beds:

1. Implement the 12 beds as agreed in 2015 and stop intermediate care in the community which involves treating as many people as possible in their own homes.
2. Continue with a model of community-based intermediate care which involves treating as many people as possible in their own homes and not implement the 12 rehabilitation beds at Teignmouth Community Hospital.

It is proposed to not implement the rehabilitation beds because:

- There is clear evidence of the success of the community-based model of care and the intermediate care team, as set out in Reason for Change 1 on pages 7-8
- The community-based model of care was supported by South West Clinical Senate, a panel of independent clinicians who reviewed clinical evidence
- The Intermediate Care team cares for approximately 880 people (both in care homes and in their own home) in a year compared with approximately 230 people a year who could be cared for on a bedded rehabilitation ward
- Teignmouth Community Hospital requires significant investment to be able to deliver bed-based care and even then would not meet modern healthcare requirements

d) Summary



To re-cap - elements of the proposal:

a) Summary

- **Now:** High use community clinics - audiology, physiotherapy, podiatry - are located at Teignmouth Community Hospital
- **Proposed change:** Move the clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre
- **After:** The same high use community clinics - audiology, physiotherapy, podiatry - would be provided at the new Teignmouth Health and Wellbeing Centre

b) Summary

- **Now:** Specialist outpatient clinics are located at Teignmouth Community Hospital
- **Proposed change:** Move specialist outpatient clinics to Dawlish Community Hospital, four miles away, except ear, nose and throat clinics which would move to the new Health and Wellbeing Centre in Teignmouth
- **After:** Specialist outpatient clinics would be located at Dawlish Community Hospital
  - Ear, nose and throat clinic would be provided at the Health and Wellbeing Centre

c) Summary

- **Now:** Day case procedures take place at Teignmouth Community Hospital
- **Proposed change:** Move the day case procedures to Dawlish Community Hospital four miles away
- **After:** Day case procedures would take place at Dawlish Community Hospital

d) Summary

- **Now:** 12 rehabilitation beds at Teignmouth Community Hospital were due to be established following 2014/15 consultation but were never implemented due the success of the new model of care, which involves treating people in their own homes
- **Proposed change:** Continue with a model of community-based intermediate care, reversing the decision to establish the 12 rehabilitation beds in Teignmouth Community Hospital
- **After:** Continue treating four times as many patients in their own homes as we could in a rehabilitation ward in Teignmouth Community Hospital

How to have your say

More information

See more information at **www.devonccg.nhs.uk/teignmouth-and-dawlish**

Share your views

Because COVID-19 is still present in our community, we are running this consultation in a different way. But there are still lots of ways to make your voice heard.

- For ease and speed, complete the survey online at: www.devonccg.nhs.uk/teignmouth-and-dawlish **Or you can...**
- Fill in the survey in this document and return it, for free, to Healthwatch Torbay at: Freepost-RTCG-TRXX-ZZKJ, Healthwatch Torbay, Paignton Library, Great Western Road, Paignton, TQ4 5AG
- Attend an online meeting, where you can watch a presentation, express your views through your phone, tablet, laptop or computer, and ask questions of the panel, who will be a mixture of clinicians and managers

The meetings are on these dates:

Friday, 11 September	2.30pm - 4pm
Thursday 17 September	10.30am - 12noon
Wednesday 23 September	6pm - 7.30pm
Tuesday 29 September	3pm - 4.30pm
Monday 5 October	11.30am - 1pm
Saturday 17 October	11am - 12.30pm

These meetings will be held via Microsoft Teams.
You can register in advance for the meetings or do it on the day, using our website. We will be directly contacting a wide range of community groups to ask if they would like to talk to us. **Haven't used Microsoft Teams before?** Don't worry, full instructions are available at www.devonccg.nhs.uk/teignmouth-and-dawlish

- Request that we attend your community meeting. Go to www.devonccg.nhs.uk/teignmouth-and-dawlish to express an interest or contact Healthwatch, as below.
- Call our independent partner Healthwatch in Devon, Plymouth and Torbay with any queries, to ask for more copies of this document, or to arrange to speak to someone from the CCG.The number for Healthwatch is: 0800 0520029
- Email us: engagement@hwdevon-plymouth-torbay.org

Healthwatch in Devon, Plymouth and Torbay is an independent patient champion for health and social care. It will be scrutinising the consultation process and will receive, evaluate and report on all feedback received.

Alternative formats

This document is also available in other languages, large print and audio format. Please contact us on 0800 0520029 if you require one of these formats.

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27/08/20
Health & Adult Care Scrutiny Committee
Thursday 10th September 2020

DEVON SYSTEM COVID-19 RESPONSE

Recommendation: that the Health & Adult Care Scrutiny Committee review this document

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DEVON SYSTEM COVID-19 RESPONSE

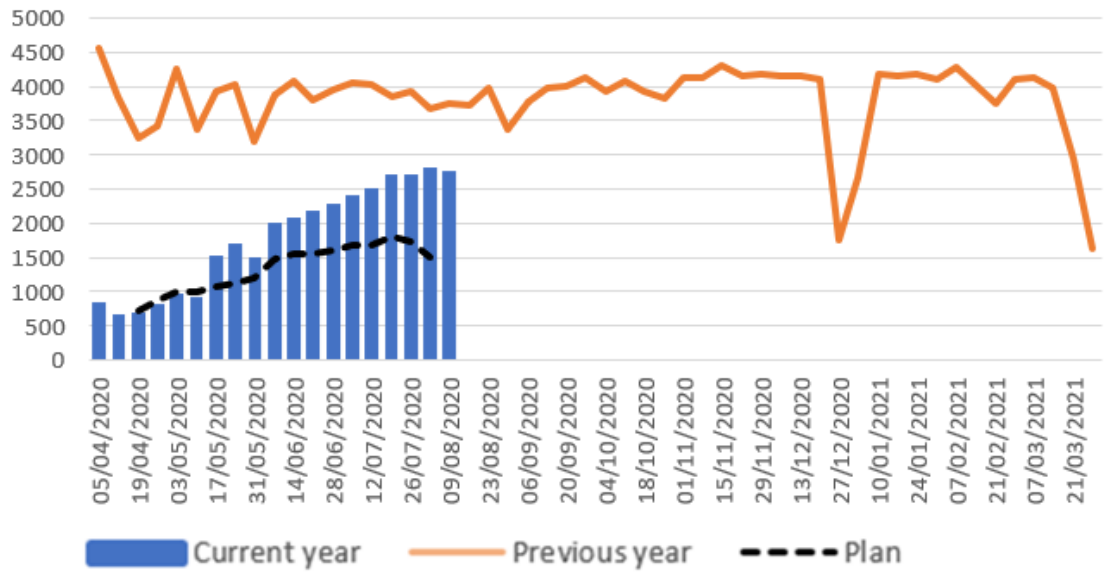
INTRODUCTION

The purpose of this paper is to build on the paper presented to the standing overview committee in July 2020 regarding Restoration and Transformation planning, focusing on further areas of good practice and innovative work undertaken during the COVID-19 pandemic response. The paper will also give an overview of Winter planning 20/21 identifying the actions the CCG and STP system need to take to fulfil national and NHSE/I winter planning requirements;

There is much to celebrate in the way organisations within the Devon system have worked together as a single system team through the COVID-19 response, showing commitment and flexibility in working to deliver the best for our local population.

ACTIVITY AND PERFORMANCE

In terms of activity, the South West recommenced elective activity faster than any other region and, within the South West, Devon has consistently over-achieved against Phase 2 plans for elective inpatient and day case activity. In the latest two weeks (ending 2nd and 9th August 2020), system information shows that STP elective activity levels were at 76% and 73.7% of 2019/20 levels - against a national Phase 3 ambition of 70% in August. This puts the system in a good position to achieve the 80% aim in September. The graph below shows the combined elective inpatient and day case weekly activity against planned levels and 2019/20 activity: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The Devon system has maintained performance against key Cancer targets throughout the COVID-19 pandemic response, improving both 62-day and two week wait performance between February and June, despite the significant reduction in capacity. As of June 2020, the CCG met the two week wait 93% target, achieving 93.07%, which is also higher than the England average of 92.5%. Whilst in relation to the 62 day urgent referral to treatment standard Devon did not achieve the target of 85% in June, again we exceeded the England average of 75.2%, with performance of 76.74%. This can be attributed in some part to the way in which Devon used available Independent Sector capacity and it has been recognised that Devon has led the way in maximising capacity available in the independent sector to provide additional space and services to support cancer and priority surgery.

Importantly, Devon has lost the fewest beds of any system in the South West due to infection control, losing just 5% of beds, compared to an average for the region of 10%.

In terms of COVID-19 infection rates, Devon has 157.9 cases per 100,000 (lowest ranked in SW and second lowest out of 150 or so upper tier/unitary authorities nationally). The South West is still the lowest region at 247.3 cases per 100,000 which compares to 490.0 per 100,000 nationally.

PHASE 2 RECOVERY – HIGHLIGHTS

1. Greater use of digital technology and innovative solutions to care and wellbeing services, including significant increase in virtual outpatient and general practice appointments. Before the outbreak, around 80 per cent of GP appointments were carried out face-to-face – now it is the opposite, with about 90 per cent of patients seen first online.

2. Local patients are embracing new technology, with more than 13,000 video consultations in Devon between April and May 2020 - among the highest of any area in the country

3. Nightingale Hospital Exeter is now providing safe and fast diagnostic testing for the peninsula for a range of conditions: CT scanning services commenced last month and nearly 200 patients have so far been seen. Ultrasound services started week commencing 10/8/20 and 100 patients have been scanned so far. It is anticipated that 2,000 ultrasound scans will be undertaken in the next 12 weeks, which will clear the non-obstetric ultrasound backlog. Almost 100 echocardiography tests have been completed since the service started last week.

4. The CCG has continued to work closely with care homes and out of hospital providers, alongside local authority colleagues. A regular webinar has provided information and shared experiences on key topics. These have been planned using feedback from the care sector. We recently published a set of system agreed principles for health and care professionals visiting care homes. The Academic Health Science Network (AHSN) is working with us to support the rollout of RESTORE2, a digital tool which will enable care homes and primary care to have early identification of deteriorating individuals. Infection, prevention and control training has been offered to all care homes across Devon and continues with domiciliary and supported living providers included.

5. In a pioneering approach to target groups who are digitally excluded, an informative newspaper was delivered to more than 300,000 homes across Devon as an essential guide to services and next steps in the continuing efforts against COVID-19. The publication was jointly commissioned by NHS Devon Clinical Commissioning Group, Devon and Cornwall Police and Crime Commissioner's Office and Devon County Council - https://tinyurl.com/y2bl4hfa (*use this link to view the paper*)

6. The need for stringent infection prevention and control (IPC) measures had a significant impact on diagnostic activity as we moved into Phase 2, doubling the time taken for CT, MRI and non-obstetric ultrasound scans (NOUS) from 15 minutes to 30 minutes, halving productivity. As the weeks have progressed, teams have worked to improve productivity whilst maintaining the same strict infection control processes and have reduced the time per scan to 20 minutes, aiming to return to 15 minute slots shortly. Given the significant constraints on diagnostic capacity in Devon, this is an important development.

7. Throughout the COVID-19 pandemic response DRSS has continued to provide referral management services, albeit contingency based, and since February 2020 has processed 99,261 routine, urgent and 2WW referrals.

8. Additionally, DRSS has supported the system in several ways;

    - Contacted over 1,500 local businesses and companies and collected over 55,000 assorted items of PPE equipment and clothing
    - Supported Devon Doctors by speaking to over 37,000 patients waiting on the Devon Dental Waiting list
    - Supported 10 GP Practices with shielding support, having made 2,000 outbound patient calls and receiving 200 inbound calls
    - Co-ordinated around 2,300 antibody tests referrals (CCG staff and GP practices - approx. 17 000 staff eligible for antibody testing within Devon/East Cornwall).

9. Launch of the first Ethical Framework and Guidance on the treatment of critically ill patients in a future pandemic like Coronavirus. The CCG linked up remotely with local community members as well as key professional groups to agree vital guidance for frontline clinicians, patients and their families and carers in a pandemic situation where health systems are at risk of being overwhelmed.

PHASE 3 - WHAT IS HAPPENING NOW?

Some of the steps we are taking to restore services include:

1. Identifying the most clinically urgent cancer patients for surgery, including use of the independent sector.

2. Reviewing all surgery lists, prioritising patients and reintroducing surgery and outpatients' services incrementally.

3. GP referrals to hospitals beginning to return to pre-pandemic levels over time, while continuing to focus on high-risk patients.

4. Continue to maintain increased community services capacity to support discharges, support care homes and predominantly support young patients and those patients with respiratory conditions or learning disabilities. Also ensuring that appropriate services and support is in place for those people who have been in hospital with COVID-19 and are now in recovery.

5. Seeking to understand the potential mental health impact of the pandemic, providing ongoing support for high risk and urgent patients. Preparing for possible longer-term increases in demand for mental health services

6. Continued segregation of infected and non-infected patients across all services

7. Enhanced discharge planning to ensure timely, safe and appropriate discharges

8. Further support to care homes including identifying a clinical lead for each care home and setting up weekly virtual 'care home round' of residents needing clinical support and medication reviews

9. Enhanced psychological support for all NHS staff who need it

10. Putting in place mechanisms to ensure closer working between the NHS, local communities and partners to increase the scale and pace of progress in reducing health inequalities.

11. GP practices are starting to address the backlog of childhood immunisations and cervical screening, as well as flu planning through their Primary Care Network (PCN)

THINGS TO CONSIDER

We will keep a constant check on the development of the pandemic locally and be guided by the Local Outbreak Boards, we will remain fully prepared to go back to full COVID-19 provision if this is required, in line with national and regional guidance. As we restore our services, we need to ensure that:

1. We protect the long-term welfare of our staff to be able to treat the numbers of extra patients. Our staff have been absolutely fantastic in their response to the pandemic and affected in many different ways by COVID-19. We must support our staff to recover before we take too many steps forward in recovering our services.

2. Our stocks of Personal Protective Equipment (PPE) are able to match service provision to ensure services can commence and continue safely to protect staff and patients

3. We want to support patients to continue to use services in a different way. Data from August shows reductions of more than 14% in our accident and emergency departments' A&E attendances compared to last year's volumes, amounting to 56,000 fewer attendances. And while some of this may have been patients who perhaps might have been best to come to A&E but were deterred by the ongoing pandemic, we expect also that many patients with minor injuries or illness decided not to attend A&E and either

used an alternative service or self-care, which is a message we have been trying to send to the public for many years.

4. We start to understand the greater impact of the pandemic on the population, both for routine care and where there might be the potential for greater complications due to patients being treated later than would normally have happened.

5. We understand the knock-on implications for different sectors and services within health and social care, not least the secondary impact of operations on primary and community care services.

WINTER PLANNING 20/21.

The Phase 3 winter plan is required at a system level with the following key requirements:

1. Continue to follow good COVID-related practice to enable patients to access services safely and protect staff, including following Public Health England guidance on outbreaks and policies on testing, applying Infection Prevention and Control (IPC) guidance and ensuring staff and patients have access to personal protective equipment (PPE);

2. Sustaining current NHS staffing, beds and capacity, including ongoing use of independent sector capacity and the Nightingale hospital to support discharge;

3. Delivering an expanded flu vaccination programme for priority groups and NHS staff;

4. Maximising use of 'hear and treat' and 'see and treat' pathways for 999 demand to reduce conveyance to emergency departments; by which a patient receives care via the telephone or by attendance of a paramedic rather than attending the emergency department.

5. Continue to make full use of the NHS Volunteer Responders scheme;

6. Continue to work with local authorities on resilient social care services and facilitate discharge.

7. Ensure the public are aware of the range services available to them, across health and social care. A system-wide communications plan is being developed.

Furthermore in order to meet the requirement to restore service delivery in primary care and community services, there are a number of requirements around out of hospital services that will be key in our winter planning. These include:

- Continuing government funding of the Hospital Discharge scheme and a requirement for systems to fully embed Discharge to Assess processes from 1st September 2020;
- Building on the enhanced support being provided to care homes;
- Enhancement of community crisis response services.

The impact of these initiatives on patient flow will be articulated within the winter plan.

The Devon winter plan will also need to reflect learning from the winter of 2019/20 and from the COVID-19 pandemic response and link to the two Devon Local Outbreak Management Plans (LOMPs) developed by local Directors of Public Health. The plan must also reflect the additional infection prevention and control (IPC) requirements of the current environment:

Workforce resilience

- Frontline Health Care Workers (FHCW) flu vaccination plans;
- Provision of adequate personal protective equipment (PPE).

Patient/public prevention & safety

- Weekly testing for health & care staff visiting care homes;
- Effective discharges (eg: continue covid testing for patient being transferred to onward care setting);
- Additional IPC support for community & primary care through the additional Community Infection Management service roles (CIM's);
- Local system outbreak management plans in place;
- Maintaining covid secure areas during high demand;
- Plans for managing co-circulation of flu & covid-19;
- Plans for supporting patient/public flu programme across community settings.

In parallel, other system-wide elements of the plan are in the process of being developed, which will address the other key requirements, 999 'hear and treat' and 'see and treat' pathways and use of the Volunteer Responders scheme. Flu vaccination plans are being developed by the System Infection Prevention and Control (IPC) lead.

Name: John Finn
NHS Devon CCG
Associate Director of Commissioning
Northern & Planned Care & Cancer

CS0/20/16
Health & Adult Care Scrutiny Committee
10 September 2020

31 July 2020 Standing Overview Group – Care Homes Testing / Recovery & Restoration in the NHS

Report of the Health & Adult Care Scrutiny Members

Please note that the following recommendations are subject to confirmation by the Committee before taking effect.

Recommendations:

That the Committee shares the learning from the most recent Standing Overview Group meeting on care homes testing and recovery & restoration in the NHS to inform its future work programme.

Background

The Standing Overview Group of the Health and Adult Care Scrutiny Committee meets bi-monthly as an information sharing and member development session where issues are presented to the councillors to raise awareness and increase knowledge. Any action points arising from the sessions are reported back to the formal Committee meeting. On 31 July 2020 the Standing Overview Group received presentations from officers on work relating to care home testing and recovery & restoration in the NHS.

Members in Attendance

- Cllr Randall Johnson (Chair)
- Cllr Ackland
- Cllr Asvachin
- Cllr Russell
- Cllr Saywell
- Cllr Scott
- Cllr Trail
- Cllr Twiss
- Cllr Yabsley

Care Homes Testing

During discussions with members the following key areas were raised:

- COVID-19 Local Outbreak Management Plan (LOMP) – the standard framework and principles for the LOMP across the area.
- The NHS integrated COVID-19 Test and Trace service designed to control the virus and enable people to live a safer and more normal life.
- It is likely that most positive tests will be individual cases; community spread would be an even greater concern.
- The comprehensive process to go through before an area is locked down.
- The excellent job care homes in Devon have done, working in partnership with the County Council and CCG. There is a very positive relationship with the local market.
- Devon has the lowest rate of care home fatalities nationally with 82 deaths (the last one in June 2020). The key factors are less COVID-19 in Devon, smaller care homes and also the local approach.
- Infection support grant of £10.5 million invested in Devon care homes. Money going to PPE, additional staff and voids in homes.
- Devon care homes locked down to visitors earlier than national guidance and remained rigorous in their approach. With new residents adopted best practice and isolated for 2 weeks, as well as a zoning approach and access to early testing.
- The importance of continuing with good infection control and prevention.
- Every care home has access to employee testing weekly – about 80% take up - with monthly testing of residents. Seeing small number of staff and residents test positive, but they tend to be asymptomatic.

Issues Identified by Members

The following issues were identified by members during their discussion with officers:

- The R rating in the South West rising. Officers advised that with 6 cases in last 7 days, the R rating was not a particularly useful indicator with very low numbers.
- Care homes. The Quality Assurance and Improvement Team (QAIT) have undertaken in depth analysis of lessons learned.
- Importance of care home visitors/volunteers. Officers would not advocate non-trained staff helping other residents at the current time.
- In terms of 'local lockdowns', officers advised that it is about risk management, patterns of movement etc. To get to a situation where the whole of Devon is in 'lockdown', it would rather be a situation where most of the country is affected. Officers would however rather apologise for locking down a wider area than apologise for not acting swiftly enough.
- Concern about wider economic impact of pandemic.
- Communication strategy. Need for proactive communication strategy. In lockdown the message was very clear, and it is now much more ambiguous leading to some confusion. There is a need for increased publicity on the good work being carried out in Devon to give communities more confidence. Officers advised that the Media & Communications Team were working hard to also disseminate positive messages, but also balanced with the need to continue to promote the importance of social distancing and hand washing etc to guard against complacency.
- The role members can have in terms of communicating with their parishes.
- In the wider population over a 5 year average, Devon does not have a high number of excess deaths.
- Eligibility on testing in adult care homes.
- Devon has high quality care homes and managers.
- Personal care market. A lot of people have not had care workers coming into their homes because of the COVID-19 risk. Officers advised that there has been financial support to those providers, PPE and a testing offer. Working with providers through care management teams to ensure people remain safe. Trying to reassure people that it is safe to have care coming in both from a social care and health perspective.
- Mental health. The importance of reminding people of their responsibilities, but not unduly creating a fear factor and forcing people to hide away. The link with mental health and physical health needs to be recognised.

Recovery & Restoration

Officers presented to members on recovery & restoration in the NHS and highlighted the following:

- On the 29th April 2020, NHS England and Improvement wrote to all NHS organisations thanking their teams for the remarkable response to the greatest global emergency in its history. The letter noted that every patient needing hospital care, including ventilation, has been able to receive it.

- The letter set out actions required as part of a second phase of the NHS response to COVID-19, based on the assumption that there would continue to be cases of COVID-19 and the need to ensure that the NHS fully stepped up non-COVID-19 urgent services within the following 6 weeks.

- The letter also asked that each organisation considered what routine non-urgent elective services could be stood up whilst maintaining capacity to deal with COVID-19 cases but recognising the need to factor in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies. The letter also asked for organisations to consider the learning from the response to the crisis and how the innovations could continue.

- NHS England laid out 43 objectives to be completed by the 12 June 2020 which came under the following areas:

  - Urgent & Routine care
  - Cancer
  - Cardiovascular Disease, Heart Attacks & Stroke
  - Women & Children's Services
  - Primary Care
  - Community Services
  - Mental health and Learning Disability & Autism Services
  - Screening & Immunisations
  - Reduce the risk of cross-infection and support the use of technology-enabled care

- The CCG had already set up at team to co-ordinate the COVID-19 Restoration and Transformation planning for the CCG. The Restoration and Transformation Team worked with groups which were already established, to deliver usual business work programmes to review the actions required and to ensure that everything was in place to deliver all the NHSE expectations by the 12 June 2020.

- The following services have been available throughout the crisis, although they may have been delivered in different ways to ensure safe delivery of services for patients:

  - Access to GP services
  - Community pharmacy
  - Urgent Optometry
  - Urgent hearing services
  - Urgent hospital services including cancer, diagnostics and emergency services
  - Mental health
  - Women & Children's Services

Issues Identified by Members

The following issues were identified by members during their discussion with officers:

- The work undertaken in phase 2 of the COVID-19 pandemic response and the planning underway in relation to phase 3.
- Devon's GP referral rate is currently around 70% of normal ("normal" being same time last year).
- 4 months of elective care was effectively lost during the pandemic.
- 52 week elective surgery waits more than quadrupled between March 2020 to May 2020. Officers advised that the priority is urgent elective care. Devon is one of the top local authorities nationally in utilising the independent sector, and through this usage during the pandemic all urgent elective care was delivered. As elective capacity increases then those with greatest clinical need will be

prioritised, which does mean those with lower needs will continue to have greater wait times. Currently at 50-70% of capacity on electives at present so wait times will get worse before they get better.

- Communication strategy on elective surgery wait times. Patients have real concern about when they are going to receive their surgery and need to be contacted. Officers recognised they need to do better with this but are starting to put procedures in place.
- Disparity in provision. Some of trusts can pick up their normal elective work quicker than others Working across Devon footprint rather than just trust boundaries, need to be flexible and understand entirety of risk across the County. Before COVID-19 there were health inequalities across the County and work continues to analyse where those inequalities are.
- Urgent lengths of stay for under 7 days remain around 60% of pre-COVID-19 levels with active discharging and restricted activity.
- Cardiology. There are ringfenced beds at University Hospital Plymouth for cardiac surgery, so Devon patients do not need to go out of County.
- Members praised work in community hospitals in undertaking minor surgeries.
- Impact on urgent care and the need to reduce the pressure on A&E.
- The impact of COVID-19 in terms of dental health.
- The need for diagnostic restoration given pandemic impact and need to address the capacity gap with CTs and MRI scans.

Conclusion

The Committee thanked the officers for attending this meeting and recognised the invaluable work they are undertaking in unprecedented circumstances responding to the COVID-19 pandemic. Members also thanked officers and their staff for working around the clock to make sure services continue to reach communities, ensuring the most vulnerable people are cared for and that frontline staff are supported.

Councillor Sara Randall Johnson, Chair
Health & Adult Care Scrutiny Committee

Electoral Divisions: All
Local Government Act 1972
List of Background Papers
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Background Paper	Date	File Ref
Nil		

There are no equality issues associated with this report