Appendix 1

Responses to resolution (b) points

Scrutiny Point 1:

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

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

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

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

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

Scrutiny point 2:

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

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

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

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

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

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

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

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

Scrutiny point 3:

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

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

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

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

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

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

Scrutiny point 4:

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

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

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

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

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

Scrutiny point 5:

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

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

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

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

Scrutiny point 6:

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

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

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

Scrutiny point 7:

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

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

Scrutiny point 8:

Closure of many care homes.

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

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

Scrutiny point 9:

Okehampton and Honiton hospitals were excluded from the consultation process.

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

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

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

Scrutiny point 10:

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

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

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

Scrutiny point 11:

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

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

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

Scrutiny point 12:

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

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

specific CCG statutory duty to address population health inequalities.

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

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

Scrutiny point 13:

Staff appear to be opposed to the plans

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

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

7th April 2017