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Northern Devon

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Northern Locality Extra-ordinary Board Meeting

Wednesday 31st August Board Meeting 2016, 9:15am – 10:30am
Crown Yealm House, Pathfields, South Molton, EX36 3LH

Part 1 – MINUTES

Present:	Dr John Womersley (JWo); Dr Stephen Miller (SM); Dr Glen Allaway (GA); Caroline Dawe (CD), James Wright (JWr)**;** Kevin Wheller (KW); Carol McCormick-Hole (CMH); Simon Polak (SP), Tracey Polak (TP); Keri Ross (KR), Lisa Heard (LH), Ruth Carter (RCa) (Minutes)
Apologies:	Dr Darunee Whiting (DW)**,** Richard Croker (RCr), Barbara Jones (BJ);
In Attendance:	Members of the Public: 14

1. Housekeeping, Health and safety, welcome, apologies and sign-in

Dr John Womersley, Chair, welcomed everyone to the meeting. Attendance and apologies were noted as above. It was announced that there were no fire alarm tests expected today, and that if the alarm sounds please make your way to the nearest fire exit and assemble in the assembly point located at the back of the car park and please do not use the lift.

2. Register of Interests and conflicts of Interest with this agenda

There are no registered interests which directly conflict with today's agenda. The ROI requires an update to remove Martin Sheldon who has left the organisation.

3. Previous Minutes – July 2016 Meeting

The minutes of the last meeting were agreed for accuracy. The actions within those minutes are to be completed by the next routine board meeting in September and are not covered within these minutes. The September meeting will be a 'Boards-in-common' meeting together with the Eastern locality board. JWo explained that boards in common remain individual boards who meet at the same time to discuss the same agenda items, this will enable wider discussion and cross-locality support on a number of items which impact across both the Northern and Eastern localities and support staff who regularly attend both board meetings. Actions taken during this meeting will be recorded and added to the list for review and completion by the September meeting.

4. Gateway Process for the closure of beds in the Northern Locality and increases in community services

JWo stated that the purpose of this agenda item is to review the gateway process which was put in place following a decision taken by this Board in May 2015. This

related to the reduction of the number of community hospital beds within the Northern Locality from 74 to 40. It was also agreed there would be a specified process and that a gateway approach would be used to provide assurance to the Locality Board that the community services were in place and were safe and effective to enable the community hospital beds to close.
It is now appropriate that this is reviewed based on work undertaken and changes over the course of the last year, both to understand what has occurred and ensure that the CCG has assurance that the outcomes are safe and effective for patients.
It was highlighted that a retrospective review of the gateway process shows that some of the gateway process had been completed whereas other areas had not been completed, and some areas are now obsolete due to the changed situation. It was also pointed out that where some items in the paper stating in writing that they are amber, they have been coloured green through error. This will be corrected.

The enclosed paper states that; 'This paper demonstrates that a thorough retrospective review was completed in August 2016 to draw together the various evidence that would support this view. It does acknowledge that the gateway process as expected by the Locality Board was not completed jointly with NDHT however offers the Board assurance that it has now been fully reviewed. There has been significant effort on the part of NDHT and CCG to establish the level of compliance with the gateway process, the data that was received by the CCG on the model of care, the detail behind the robust reporting and assurance frameworks for TCS in North as well as the evidence of new relationships being forged within the Success Regime ethos of collaborative working. We are now in a different place'.

It was stated that NEW Devon CCG is now part of the Success Regime, this includes both commissioners and providers working together in a more collaborative and open way which is still developing and moving at pace. The Gateway process was written at a time when the CCG didn't have sufficient data streams for assurance, which has now improved. The paper submits that 'The retrospective review suggests that the Locality Board can be assured that safe and effective community services are being provided in place of bed based community care for more people, and has received assurance of a change of governance which would ensure that changes of this nature would be overseen as part of the wider system (Success Regime) and with full participation of all stakeholders. This paper therefore recommends that members accept the assurance given of safe and effective care as a result of this review, despite the gateway process not being completed as originally intended'.

JWo called for any opinions on the paper from board members at this point. JWr stated that the success regime is a significant change and that in the context of the gateway and the process last year, this needs to be reflected in the current process and assurances requested.

Prior to discussing the recommendations within the paper and any further assurances required by the board members, JWo declared that a number of questions had been submitted under item 5 of this agenda that relate to this agenda item and asked the board members if they would be content to hear the questions and prepared answers alongside this agenda item in order to enhance the information and discussion in relation to the recommendations within the enclosed paper; this was agreed.

ACTION - a full list of the questions submitted prior to the board meeting as per the approved process, and the answers to accompany them, are to be included within section 5 below and also posted on the locality website.

Questions relating to the agenda item were read with corresponding answers (see below). A number of the other questions were not felt to be directly related to the agenda for today's meeting and as such will be answered below and on the website but were not directly covered by the meeting.

A number of other questions and statements were broached by members of the public during the meeting however this was a board meeting held in public, not a public meeting and as such the process is for questions to be submitted in advance of the meeting not taken during the meeting. The chair did on this occasion allow a few comments where they related directly to the item of business or previous questions asked. This question and answer process is to enable the focus to remain on the items of business on the agenda to the specified timeframes during the meeting and to ensure that informed, correct and comprehensive answers can be given to those submitting questions. Further questions and comments could be submitted at the meeting through the feedback forms handed out to the public attendees.

JWo clarified that the purpose of today's meeting is to review the gateway process and to consider the recommendations with a view to approving the paper. It was emphasised that no further service changes are being proposed or raised for discussion at this meeting. Questions relating to future service changes can be submitted during any future consultation processes, for example further reducing community hospital bed numbers but this is not part of the business on the table for today's meeting.

Discussions around the answers to the questions highlighted that the CCG require a regular stream of more detailed data, specifically around smaller communities including outcomes and metrics such as staffing. For example, submitting data which puts together the community staffing numbers for two community areas does not give a clear picture on the staffing of each individual area, such as Holsworthy and Torrington. Therefore granularity of detail is important for further assurance.

A member of the public queried the figure of hospital beds being 32 rather than 40, JWo stated that two community hospitals are regularly using 16 beds, with the ability to use a further 4 beds on each site at any time – this was referred to as 'flexing' the capacity when it was needed and may require additional staff. These beds, it was confirmed, are not closed, however they are infrequently required and the remaining beds are not being utilised to full capacity. It is for the providers to decide which patients go into a community hospital bed, these patients have different health care requirements to patients in the acute hospital and many patients are now able to be discharged home, without the requirements for a community hospital, with improved admissions processes, links to community services and packages of care in the community.

Following the discussion the recommendations on page 15 of the enclosed document were reviewed and some changes to the document wording will be required.

SM stated that “I am fully supportive of the direction of travel proposed in the transforming Community Services and New Models of Care papers and it is highly likely that 32 beds flexing to 40 is an appropriate number of community beds. In voting for 40 beds, I think we probably erred on the side of caution” SM went on to state that the evidence that was presented by Northern Devon Healthcare trust is encouraging and that through the success regime process we now have clear assurances from Northern Devon Healthcare Trust that we will be fully signed up to cooperate together in developing and implementing the plan for community services and using appropriate outcome measures to assure commissioners and the public that what is happening is both safe, effective and appropriate care. However, the information submitted does not satisfy all of the gateway process previously agreed and that he would require a change to the document wording prior to being able to fully support it. SM further stated that staffing levels presented in the ‘as is’ paper from the provider do not provide enough fine detail for assurance, also views of local stakeholders including GPs, town councils and community clinical staff have not been included as well as some of the other metrics previously used to assure the community bed closures in Torrington were safe. These details need to be included.
He agreed with a questioner from the public that in the assurance template many of the gateway criteria would be better shown as amber rather than green and questioned whether the PWC assessment on community service finances was the most up to date assessment.

CD stated that the paper was designed prior to the new ways of working within the Success Regime. Additional assurances are however required and the board needs to decide what those additional assurances are.

It was agreed that the conclusion statement required changing to;

‘The Locality Board have some assurance that safe and effective community services are being provided in place of bed based community care for more people but require further information.
We have received sufficient assurances over the last 10 months and are now in a position to confirm the themes of the gateway processes are being taken forward’.

It was also agreed that additional points are required to be added to the recommendation which will now read as;

‘The recommendation to the Locality Board is that it should agree that themes of the gateway process have all been reviewed and are described in the attached table.
Although some steps cannot be completed retrospectively, nonetheless safe and effective care is being provided with a reduction in community hospital beds and an increase in community services in the Northern Locality, in accordance with the gateway process.
The approval can be given as the additional assurances are in place so that:

- The collaboration and relationships developing within the Success Regime mean that any changes to any service are jointly agreed, developed and implemented in future with the involvement of all partners across the provision system.
- The Success Regime will take a lead in developing new models of community care through the New Models of Care work stream, but NDHT and the Northern Locality will ensure that the clinical and patient engagement which

was bedrock for the Care Closer to Home consultation in the North will strongly influence this work stream.

- NDHT and the CCG have signed up to be key members of the success regime developments and its governance processes.
- NDHT have committed to working with the CCG on the service development improvement plan which is acknowledged as a demonstration of the collaborative principles of the Success Regime. The actions are confirmed and the timetable for implementation will be agreed.
- NDHT have committed to working with the CCG on the specifications as they currently stand with a joint timetable for improvement which is described in memoranda of understanding. The shared requirement is to move rapidly to outcome/output based specifications.
- NDHT have committed to providing a shared data set with regards to activity and performance and agree any changes jointly in going forward.
- In the absence of outcome measures being agreed and fulfilled, staffing levels provide a crude assessment of the adequacy of community services. A more detailed breakdown than has already been provided is required and commissioners would anticipate any major differences to be addressed by the provider.
- In the case of Torrington further assurance was sought through the views of the GPs, senior clinical community staff, town councillors, call to ambulance services and calls to out of hour's services. We request this information for the communities in Bideford and Ilfracombe'.

A vote was taken based on the revised recommendations. The outcome was 4 out of 4 present voting members voted in favour and approved the paper recognising that the further information requested would give full assurance.

5. Written questions from the public (Standing item)

Please see appendix 1

6. Reflection on the effectiveness of the meeting

The board were asked to reflect on the usefulness of the meeting and deemed that;

- It is difficult when there are clear sensitivities to items being addressed to keep a clear line between a meeting in public and a public meeting. On this occasion it was considered appropriate that some comments were taken during the meeting where they were directly related to the agenda.
- The board are focused on the outcomes for patients and ascertaining that processes are followed to ensure services are safe and effective by holding the provider to account, and the new Success Regime enables the CCG to do that in a much more cohesive and supportive manner.

7. Date and time of next meeting

Dr John Womersley closed the meeting at 10:53am

The next meeting will take place on 28th September at 09:30am at Crown Yealm House. This will be a meeting of Boards in Common with the Eastern Locality Clinical Board.

Actions from the meeting

1	Ruth Carter	Ensure questions and answers are published in the minutes and on the website, with appropriate website / documentation links where required, as close to the meeting as possible.	Within 7 days of the meeting.	
2	Ruth Carter	Forward the revised wording to be included within the paper to the relevant person	Within 7 days of the meeting	

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Signed;

Date;

Name; Dr John Womersley

Job Title; Chair

Appendix 1 - Answers to Questions submitted by members of the Public prior to the Extraordinary Board Meeting Wednesday 31st August 2016

(Questions submitted as per the approved process)

1. Do you think retroactive authorisation/approval of 34 community bed closures by the CCG, nearly half the total capacity, is acceptable given the serious clinical and community implications of such a huge one-off cut in capacity?
Whilst the Locality initially planned that the closure of the beds would be through a joint process to provide assurance of the safety and effectiveness of the alternative services, NDHT undertook a l consultation process and presented to the Devon Health and Wellbeing Scrutiny Committee. They are, as the provider responsible for providing safe care and undertook all of the appropriate risk assessments.
As stated in the paper although the gateway process did not take place as originally planned, the evidence provided by the service provider shows that safe and effective care is being delivered and we understand that they have shared this with the OSC as well.

We had also wanted greater primary care involvement in the future model and to be able to influence more directly the reinvestment of the resources to increase community services.

2. A year ago, the CCG expressed serious reservations about such a cut in the number of community beds and criticised NDHT for the speed and means by which is was going about such a change. Why are you now retroactively endorsing not only that decision but, in effect, the means and speed with which it was carried out?
This links with the question and answer above. The paper for today's board indicated our reservations at the time and, we have therefore used our time to gain assurances that the new partnership of the Success Regime in Devon will ensure that services work in partnership and sign up in advance to a comprehensive gateway process before changes can be implemented. We have been working with NDHT to improve our partnership processes and are much more confident of the approach that will be taken jointly in the future.

3. You suspended, but never cancelled, your own review, into the required level of need for community beds in North Devon, in the face of what seemed to be a pre-emptive strike by NDHT in the summer of 2015 as they announced their own

"consultation" as to where 34 beds would be cut. Can we please see your own review and review what conclusions you came to.
The CCG had undertaken its own work which indicated that we believed there was a need for more community services and less community hospital beds. It was never our intention to determine the location of these beds as this had many demographic and operational considerations. This was covered in the locality board paper of May 2015 which describes the range of issues which would need to be considered when determining the future location of the beds. Our intention was to work with the public and various stakeholder groups to consider each of the issues which had been raised as important as part of our consultation and 'weigh' their importance to help to come to a final view. NDHT did take the structure of the process being proposed in our document and used this to model the consultation, but we never carried out an independent review.

4. The Gateway Process document makes it clear that numerous metrics and measures have not been agreed or put in place. Phrases like: "Key outcome measures not agreed," and "the measures need work" litter this document. How can you justified both the 34 original community bed closures and the now on-going surreptitious bed closures (only 28 of the original 40 community beds agreed last year still remain today, 12 in Holsworthy, 16 in South Molton) with such self-declared inadequate metrics and measures for measuring the impact of such massive changes?
The metrics we would use to review the service change had been agreed with NDHT as the right ones to demonstrate the service was safe and effective. However what we haven't had is a regular stream of this data which allows us to look at smaller communities in this level of detail on a regular basis but this has now been rectified.

The NHS is also being asked to move from collecting data which describes numbers i.e. Mortality rates and length of stay data and numbers to testing and measuring the experience of the person receiving the service. This is a challenging move and creates nervousness for everyone in being sure that the right data is being collected. This needs to be done jointly by the provider with the commissioner and also users of the service. This did stall for reasons described in the above answers.

There are 40 community hospital beds available to use in the Northern Locality. Currently there is staffing in place to safely manage 16 beds in both hospitals but both have the ability to flex to 20 beds if required at times of escalation. As a consequence of improvements in patient flow and management in NDDH and the implementation of new models of care there is no longer the number of appropriate patients to fill the available beds. This has resulted in empty beds, especially in Holsworthy community hospital. The GPs serving Holsworthy community hospital are managing their own patients and there has not been an operational need to fill the consultant managed beds.

5. Is it true that the new GP out of hour's contract, starting October, makes no provision for out of hours cover for patients in community hospitals? Is this not an obvious means of declaring community hospitals and unsafe as of this autumn, thus forcing the closure of the remaining 28 beds in South Molton and Holsworthy?
The out of hour's service in Devon has provided cover for the community hospitals but it has never been part of core business for the service. It had been an unfunded,

unspecified add-on service. The benefit of going out to procurement is that it has exposed the anomaly and the community hospital cover is being provided through a separate contract. Therefore it is not correct to say there is no provision for clinical cover for community hospitals. In the short term it will continue to be provided by Devon Doctors, but each of the community hospital providers across the county are considering if there is a better model for the future.

6. What further bed closures are planned?
At the moment there are no further community hospital bed closures planned in the northern locality. We do however recognise that changes in technology and increases in community services do challenge the current role of community hospital bed based care. We acknowledged this in our original document which went to the Locality Board in May 2015 which determined the numbers of beds we thought were needed. (Excerpt below).

7. Why do we need community hospital beds at all?
In undertaking this review of bed usage and future needs we have challenged ourselves to consider if we need community beds at all. We have been reviewing the information available in the National Audit of Intermediate Care which has just reported on the year 2014. This survey suggests there are many communities where there are few or no beds at all and all activity occurs in the patient's own home. Conversely there are some communities which have more beds than we currently do. Beds are part of the whole system of community services and in most instances numbers are a consequence of history and ability to develop community services to replace them.

We can see in the future that technology will change again and we do anticipate our bed usage will reduce again. We anticipate greater frequency of hospital beds being used just for rapid access diagnostics and treatment, a quick turnaround and people then having their care continued in the community. As bed based care is so costly and patient expectation drives a care closer to home agenda, we will see reducing lengths of stay and bed based care.

In the future we anticipate beds will be used for people who need some type of intervention which can only be undertaken on a site where they may be able to access complex equipment, services or a combination of clinical specialists. This need may be better served by the acute hospital where there is access to the complex equipment for diagnostics and treatment, operating theatres and a hub of a variety of clinical skills for people who have greater complex needs.
We anticipate seeing community hospitals changing their role to develop and offer day case care, simple diagnostics and outpatient facilities in partnership with other health and social care related services. We also anticipate that reablement will become a core function for community hospitals.

At this stage however our ability to predict a point at which no beds are necessary has too many variables. We also understand that the community services we have in the Northern locality are good as defined by the CQC, but we are still challenged by gaps in provision and need to provide equitable services across the patch so that everyone has access to them for all functions we require community services to deliver. We think an incremental approach to

This development is important so would not want to contemplate removing community beds entirely from the equation.

8. Who has been responsible for the risk assessment, associated with each specialism, in drawing up the proposals for change in healthcare service delivery affecting Northern Devon Healthcare Trust? Please provide details of the clinicians involved in the process to date, their designation and place of work.

The work related to increasing community services was prefaced by a literature search of evidence (see question below) which supported public views that people would prefer to be cared for in their home whenever safe to do so. Your question asks for the risk assessment based on specialisms - this work has been based on a group of people with various conditions and clinical needs that do not need to have care in acute hospital setting, it does not target specialisms.

The enhancement in community based services in the northern locality has been led by North Devon Healthcare Trust (NDHT) with support from the CCG. NDHT have undertaken a quality impact assessment and have also shared data which shows that the impact of the closure of the beds and use of the funds for more community services. This work has also been presented to the Devon overview and Scrutiny committee.

The work has been clinically led, by Dr Chris Bowman, Assistant Medical Director, Rob Sainsbury Director of Operations and Stella Doble, Assistant Director Health and Social Care are the three leads for NDHT, all of whom are clinicians. I cannot give you a list of all of the people involved in this work to date but will ask NDHT to advise.

9. Could we have a copy of the Impact Assessment?

Yes, this was provided by NDHT as part of their safe and effective care within a budget consultation which recommended the final location of the remaining beds in the northern locality.

Quality Impact Assessment of the Transformation of Community Services as part of Safe Effective Care within a Budget, please follow this link;
http://www.northdevonhealth.nhs.uk/wp-content/uploads/2015/09/Annex-5.1-Board-06.10.15-Community-Hospital-Consultation-Appendix-ii.pdf

10. On what clinical evidence have you determined your 'new models of care'?

We attach a copy of an original clinical literature search which was undertaken by public health colleagues which summarised:

There is good evidence that hospital at home care is at least as safe and effective as care in a hospital setting, as long as patients are carefully selected. The evidence outlined in this paper is relevant to older adults across a range of conditions. There is robust evidence from three Cochrane Systematic reviews, and other supporting sources, that hospital at home patients have similar or reduced levels of mortality, similar levels of readmissions and fewer patients being in residential care at follow up than in-patient care. Hospital at home also significantly increased patient satisfaction.

Item 7 A Appendix 7 Evidence Review - Fi

11. What is the primary reason for the proposed – and recently implemented - changes to the Healthcare service?

a) **Is it to improve healthcare?**
b) **Is it to save money? Looking at the CCG Strategies, Priorities and Core Objectives 1, 2, 3, 5,6 and 7 of the 8 appear to be cost-driven. Even number 4 includes 'cost effective' as a parameter.**

Our argument would be both. Additionally we would also argue that community hospital bed managed care is not an attractive option for recruitment and retention of staff and, in an environment where the ability to secure the right numbers of doctors, nurses and therapists to care is an ongoing challenge it cannot be dismissed as an important factor.

You will see from the clinical evidence collected by our public health colleagues that there is good evidence that hospital at home care is at least as safe and effective as care in a hospital setting, as long as patients are carefully selected.

We know that care provided in community hospitals is sensible when the level of clinical need required to be provided into a person's home is high or the timing is unpredictable. From a cost perspective we have also worked out the point at which it is more cost effective to care for a person in a setting where there is already clinical staff available at all times, rather than offer to services at home when needed.

Our community hospital beds are not well used and audits undertaken by Public Health show that up to 40% of people being cared for in community hospitals should not be there, and in the 'safe and effective care within a budget' consultation NDHT were able to demonstrate how many more people could have care provided for them in community settings rather than funding bed based care in community hospitals.

You will be aware that the health services are severely financially challenged in Devon, spending money at the moment which it has had to borrow (and will have to repay). We will always be looking for ways to provide safe care and reduce costs.

12. Please explain what you mean by 'place-based care' and where the idea originated.
This is a helpful and succinct document from the Kings Fund which will describe much of the background.

http://www.kingsfund.org.uk/publications/articles/nhs-agenda-for-action?gclid=Cj0KEQjw3ZS-BRD1xu3qw8uS2s4BEiQA2bcfMyFwKDMyHy5PwgD41RzUwoIxYRSgLsSoHIxIUVDIIAYaAuDM8P8HAQ

13. Please explain what you mean by 'Gateway process' and where the phrase originated.
The gateway approach was coined we believe by the Office of Government Commerce and is used widely in programme management to alert project and programme teams to the need to make sure that all actions have been completed to

move onto the next stage of a project or programme. I've attached a summary which may be helpful background.

https://www.gov.uk/government/.../Gateway_2_Workbook_Word_Template_v2.0.do

14. How can 'new models of care', hitherto untried, be undertaken without ensuring that the outcomes are at least as good as the systems you are replacing?
Please refer back to the public health evidence highlighted in the answer to Q10.

15. Please explain what a system control total is and what is the actual value of the 'new system control total' is.
Because of the financial challenges of the county in relation to healthcare the main organisations are working together under the umbrella of the success regime. (You will see this described in the paper for the 30th August). One of the challenges for healthcare is the current contractual relationships where money follows the patient, this creates financial risk for the providers of healthcare and the commissioners as the provider doesn't know how much it will have as income and the commissioner will not know if they can afford to pay the bills. This sometimes creates unhealthy environments as one organisation is trying hard to minimise its cost, whilst another may be looking to maximise their income.

The organisations in Devon who are part of the Success Regime are:

- Northern, Eastern and Western Devon Clinical Commissioning Group
- Northern Devon Healthcare Trust (acute and community services).
- Plymouth Hospitals NHS trust
- Royal Devon and Exeter Foundation Tryst
- Devon Partnership Trust

The organisations above have worked together to agree the financial envelope they will work within for 16/17. The cost of providing and commissioning services however exceeds the financial envelope available and this creates a collective deficit for the organisations involved. The collective deficit is the 'System Control Total'. The agreement between the 5 organisations removes the tension referred to above by fixing the financial envelope each organisation needs to work within. This will allow the organisations to work as a system to focus on safely reducing cost and management of the financial risks inherent in the Devon healthcare system.

Answers provided by Dr John Womersley, Dr Stephen Miller, Caroline Dawe, Kevin Wheller and Elaine Fitzsimmons