The Extraordinary General Meeting of Northern Devon CCG 31st August 2016

Overview of purpose and outcome of the meeting

This morning at the extraordinary public meeting of Northern Devon CCG the main item under discussion was the 'gateway process' for the closure of beds in N. Devon community hospitals and introduction of 'care closer to home'. The 'gateway process' was set up last year as a set of key requirements to enable the CCG to be assured that bed closures and the resultant increase in community provision provide safe and effective care. The review was intended to perform a retrospective analysis of the gateway requirements, determining which items are complete, no longer relevant, or moving in the right direction.

The conclusion was that there was some assurance that "safe and effective community services are being provided in place of bed-based community care for more people" but that more detailed information is required. Also there were "sufficient assurances over the last 10 months… to confirm the themes of the gateway process are being taken forward".

What this means is that the CCG were not happy with the manner in which community beds were cut (lack of collaboration between CCG and NDHT), that the evidence of efficacy is insufficiently detailed but that nonetheless they believed that the detailed evidence would become available as time goes by: their belief is based upon the change to collaborative working as opposed to the previous confrontational relationships between commissioner and provider organisations.

Commentary

The cuts to community hospital beds were made without evidence that the replacement services, 'care closer to home', result in outcomes at least as good as the ones replaced. Not only were the changes made without evidence there are also concerns at the level of detail data which is available.

The evidence, such as it is, given by NDHT to CCG, also given to Overview &Scrutiny, indicates that the new model is 'safe'. What exactly is meant by 'safe'? And safe for whom? The experience in Torrington is that the system of care closer to home has failed: DCC's scrutiny committee agreed it had failed in Torrington and sent the case to the Secretary of State.

The CCG view is that 40 community beds are needed; that there should be more community services and fewer hospital beds. NDHT report that the current community beds are under-utilised and they have in place staffing for 16 beds in each of two hospitals with the potential to flex to 40. It was not clear if the under-use is a deliberate policy of NDHT but it seems likely to be the case. What type of data is collected supporting the decisions to provide community-based rather than hospital-based care? Where can we access this data? What evidence is there that the decision was the right one?

The nursing ratio of 1:8 as given by NDHT as the reason for closure of community hospital beds to make them 'safe' was actually a ratio for *acute* beds. In a community setting a lower ratio would suffice meaning that the reason given for closing beds in Torrington and Ilfracombe was not valid. It would also indicate that it is cost which is the main

driver: it is certainly the case that 40 beds distributed between 4 hospitals would have a higher cost per bed than 2 hospitals. The communities affected by the loss of their in-patient beds, however, were not consulted on this decision – accessibility is a key factor for patient, friends and family.

Note: the provider decides who uses the beds (not the CCG); admission levels at NDDH have been flat for the last couple of years; a further consultation exercise would be necessary for the number of community beds to fall below 40.

Metrics related to the changes in service have been agreed with NDHT and Overview and Scrutiny. Data on mortality rates, length of stay etc. can easily be collected but apparently more importance is to be given to patient experience. I wrote that down but cannot believe that it can be right. One of the biggest problems I have with the current experimentation in the NHS with their 'new models of care' is that they do not appear to have any – or much – evidence and are trying things out to see what works. I'm sure it is important that patients feel that they have received the best possible treatment but such subjective assessments are surely 'not safe' as evidence of efficacy. Not surprisingly this approach has currently stalled: there are difficulties in working out how to relate this to outcome measures. They have not received a regular stream of data from the provider and it was felt that the data they have received lacks a sufficient level of detail: Torrington & Holsworthy are reported as a 'cluster' as are Ilfracombe and Bideford, e.g. number and types of staff are given for a cluster rather than an individual hospital making it impossible to know if comparisons between Torrington and Torrington-with-Holsworthy are valid.

More notes on metrics: It would appear that NDHT are determining what metrics to collect. If this is the case then surely it is at odds with the concept of nationally collated statistics – it certainly seems to be that there is a disconnect between statistics gathered pre and post the 2012 Health and Social Care Act so how can meaningful comparisons be made (this does need checking – it is possible though unlikely that there is a continuum).

What is a system control total? Given that this was mentioned in the gateway document I had expected an answer. Instead we were told this was a question for the governing body, the Success Regime, and the providers (NDHT). They will publish a brief answer on the web-site. I presume this is some sort of financial control though it may not be.

Reduction in bed numbers and increase in community care: there are clear assurances from NDHT that they are fully signed up to the Success Regime in future and to providing outcome measures to reassure that outcomes are good. There was no explanation of what those measures are/would be.

Skills mix and basis not provided by NDHT. Face to face time in Bideford has not changed (it should have increased) but it went up in Ilfracombe and Torrington.

Concerns were raised with the outcomes of the gateway process:

- Torrington: response from consultees - doctors, councillors etc.- should be readily available and reported by NDHT.
- Additional assurances (of success?) are needed.
- The CCG do not yet have tools for measuring outcomes. The goal is outcomes-based commissioning – how do we measure that? Not there yet. Is this what they mean when they talk of using 'patient experience' as evidence?
- Not all criteria specified in the gateway process have been met, however the involvement of the Success Regime has removed the need for some of them.
- Staffing levels provide a crude assessment of effectiveness of community services – more detail is needed. Note: number of calls to ambulance and out-of-hours service should be requested for North Devon services as a whole, include GPs etc.

Two caveats to the gateway process were given:

- Collaboration à la Success Regime where future changes are to be jointly agreed
- New models of care: that care closer to home strongly influences this work-stream

It was also indicated that though every item in the gateway document was green-lighted apart from two which were amber most of them probably ought to have been flagged as amber. The first two items upon which much that followed was reliant were down-graded to red by the vice-chair (ref. Phillip – I missed that).

Domiciliary care arrangements were not referenced in the gateway process – but should be.

<u>Various questions and statements not relating directly to the 'gateway process'</u>

There was a question about Devon Doctors losing the out-of-hours contract from October and there being no cover out of hours for community hospitals. Apparently there would have been gaps in the service because community hospitals were not part of the original contract; however Devon Doctors will continue to provide out-of-hours cover for community hospitals, i.e. there will be no change in this service. For how long? It was implied that this cover by Devon Doctors was short-term: how short and in transition to what? Closure?

Impact Assessment: will be part of the new consultation and will be put on the CCG web-site.

Clinical research papers will always be put on the web-site: studies also available on NDHT web-site with comparisons to local data.

The CCG have a budget they are not allowed to exceed (see web-site).

What is 'place-based' care? (This question was asked because it derives from Kaiser Permanente, a large health and insurance provider in the USA responsible for Medicare). We were referred to a paper by the King's Fund which provides a summary of place-based care: also see 'Getting communities to work together' on the web-site and the link to the Office of Government *Commerce*. Why is the NHS referencing an organisation with 'commerce' in its title?