HEALTH AND ADULT SOCIAL CARE
OVERVIEW AND SCRUTINY COMMITTEE

Date : Tuesday, 5th April, 2016
Time : 10.00 am
Venue : Trelawny Room, County Hall, Truro, TR1 3AY

Agenda

1. Apologies for Absence
2. Declarations of Interest
3. Minutes of Previous Meeting held on 24 February 2016 (Pages 1 - 11)
4. Oral Update from the Portfolio Holders for Adult Care and Young People
   Please note that the Oral Update from the Portfolio Holder for Young People will be restricted to children’s health
5. Public Questions and Statements
   An opportunity for members of the public to ask a question or make a statement to the Committee.
   (A period of ten minutes is allocated this purpose.)
   Questions and statements to be received by the Monitoring Officer by 12.00 p.m. on Thursday 31 March 2016
6. Questions from Members to the Portfolio Holders
   An opportunity for Members of the Council to ask a question of the Portfolio Holders.
   (A period of fifteen minutes is allocated for this purpose).
   *Please note that questions to the Portfolio Holder for Young People should be restricted to children’s health
7. Cornwall Deal - Health and Social Care Integration (Pages 12 - 22)

8. NHS Kernow - CCG Legal Directions (Pages 23 - 25)

9. Improvements to Urgent Care in Camborne Redruth Hospital and Closure of Cardrew Health Centre (Pages 26 - 95)

10. Temporary Closure of Edward Hain In-Patient Unit (Pages 96 - 98)

11. Final Report of the Select Committee Review of Care at Home (Pages 99 - 189)

12. Section 135/136 Safe Places Provision (Pages 190 - 191)

13. Any Other Business that the Chairman Considers to be of Urgency

NB: The Local Government (Access to Information) Act 1985 prohibits the consideration of any items which have not appeared on the agenda for the meeting unless the Chairman is prepared to certify that a proposed item is ‘urgent’. If urgent, the special circumstances which make it so, must be spelled out to the meeting and included in the minutes.

Richard Williams
Monitoring Officer

Enquiries on this agenda to Leanne Martin, Democratic and Governance Officer or email at

Committee Membership

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Councillors:

- Chopak
- Fonk
- Parsons
- Rix
- Rotchell

- Eathorne-Gibbons
- P Martin
- A Mitchell
- J Thomas

- Bastin
- Gorman
- Nicholas
- Sanger

- Atherton
- (None)
- Jenkin
- (None)

Substitutes

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Councillors:

- Buscombe
- Frank

- Burden
- Penhaligon
- (None)
- (None)
- (None)
- (None)
Where a Member of a Committee is unable to attend a meeting he may arrange for a substitute to attend from his Party Group, drawn from the list of substitutes approved by the Council. The Democratic Services Officer nominated by the Democratic Services Manager to service a committee must be notified, normally by the Member of a committee to be substituted, orally or in writing of the substitution before the commencement of the meeting. If this requirement is not met, the substitute shall not be permitted to participate in the meeting.

We want to ensure that your needs are met. If you would like this information in another format or language please contact:- Leanne Martin, Democratic and Governance Officer, on 01872 322487 or e-mail democratic@cornwall.gov.uk
CORNWALL COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW
AND SCRUTINY COMMITTEE

MINUTES of a Meeting of the Health and Adult Social Care Overview and
Scrutiny Committee held in the Trelawny Room, County Hall, Treyew
Road, Truro on Wednesday 24 February 2016 commencing at 10.00 am.

Present:- Councillors: Rotchell (Chairman)
Eathorne-Gibbons (Vice-Chairman)
Atherton, Bastin, Chopak, Eathorne-Gibbons, Fonk, Jenkin,
P Martin, A Mitchell, Nicholas, Parsons, Rix, Rotchell and
Sanger.

Also in attendance:- Councillors: Dolley, Eddowes, McKenna, P Rogerson and
Wallis.

Apologies for absence:- Councillors: Gorman and J Thomas.

ELECTION OF CHAIRMAN
(Agenda No. HASCOSC2)

HASCOSC1 It was moved by Councillor Parsons, seconded by Councillor
Martin and

RESOLVED that Councillor Rotchell be elected Chairman.

Councillor Rotchell thereupon took the Chair and thanked Members for his
election.

ELECTION OF VICE-CHAIRMAN
(Agenda No. 3)

HASCOSC2 It was moved by Councillor Martin, seconded by Councillor
Parsons and

RESOLVED that Councillor Eathorne-Gibbons be elected Vice-Chairman.

DECLARATIONS OF INTEREST
(Agenda No. 4)

HASCOSC3 There were no declarations of interest.

ORAL UPDATE FROM THE PORTFOLIO HOLDERS FOR ADULT CARE
AND YOUNG PEOPLE
(Agenda No. 5)
The Portfolio Holder for Adult Care provided an update on the Council’s decision relating to the council tax and the 2% levy for adult social care which had attracted public attention. A separate account was being established for this levy to ensure it was spent on its intended purpose, rather than being part of the general resource.

The Portfolio Holder then went on to discuss the public meetings that were starting on 8 March 2016 relating to health and care devolution. A series of eight meetings had been set up. A questionnaire was also in circulation and had, thus far, received approximately 1,200 responses. The deadline for return of the questionnaire was 25 March. The purpose of the consultation was to enable the public to be heard. Healthwatch was coordinating the views of stakeholders. The Plan itself had to be agreed with the Government and NHS England by 30 June 2016. In response to a formal request from a Member of the Committee, the Portfolio Holder confirmed that he was more than happy to arrange an additional consultation event in Falmouth.

The Portfolio Holder for Young People also referred to the consultation events relating to integration as it also applied to children’s health services.

QUESTIONS FROM THE PUBLIC TO THE PORTFOLIO HOLDERS
(Agenda No. 6)

One question was received from Mr Chappell of Redruth relating to Urgent Care in Camborne Redruth Community Hospital and Closure of Cardrew Health Centre. He referred to the recent disclosures concerning the proposed closure of Cardrew Health Centre in Redruth. He knew that many people were as surprised as he was to have been informed of this news and that those responsible for making this decision did not see fit to consult with the local MP let alone anyone else showed an unbelievable level of discourtesy and even beggared belief. This was an issue which was very much of public concern, not only in the wider Redruth area but further afield.

In last week's West Briton, the Practice Managers of the two remaining GP Surgeries in Redruth, notably the Manor Surgery and Clinton Road Surgery called him to account for one of his comments reported in the newspaper which intimated that both surgeries were struggling to cope. Both managers issued a joint statement informing that they were able to cope with the 3,200 or so patients who would be forced to seek alternative registration following the closure of Cardrew. However, he had not made that remark, as reported, without evidence gained from the public including his own personal experiences at one of the surgeries and indeed from other authoritative sources.

At a full council meeting of Redruth Town Council held during Monday 8th February, 2016 and to which a number of members of the public attended and spoke, he stated that he was able to quote verbatim the comments
from people regarding the service they had received as well as citing material from the National Health Executive Journal leader article dated 3rd February, 2016 and the survey commissioned by the British Medical Association (BMA) during December last, 2015, only a month ago. Not only did this material completely contradict the comments of the practice managers, but it also reflected the views of General Practitioners in this area.

The BMA had produced this so called 'Heat Map' survey in December, 2015 which contained results of a survey of GPs in this constituency area amongst many others. It was instructive to note that the survey revealed doctors in the Camborne and Redruth area felt that the 'level of demand had increased', the 'current level of workload was unmanageable' and the 'quality of service had deteriorated.' He had made both practice managers aware that their public statement was in complete contradiction to the views of their own doctors and he awaited their responses with considerable interest.

In case anything untoward should happen to these findings by the BMA, he had obtained screen shots of them and had circulated them to the Committee, together with a copy of my letter to the West Briton in response to last week's article.

He also retained the comments made by frustrated patients (he had their personal details but many were too frightened to speak out for fear of being denied medical care having been declared vexatious) and these were further confirmed by remarks made at the meeting of the Town Council by the wider public and where even a Cornwall Councillor present expressed her concerned views. These comments, which he appreciated constituted only a straw poll at best, would now be a matter of public record.

In a 2014 report commissioned by the NHS, the Cardrew Centre was held up as a prime example of efficient health care delivery and this finding had been corroborated by the wider public. He could not say that he had ever heard a critical word spoken of the place. Even more astonishing now though, was the revelation made by a member of the public at the Council meeting which revealed that last year a doctor in general practice, two nurses and a nurse practitioner had put forward a bid to run Cardrew Health Centre to be informed that the decision to close had already been made. This was apparently 'hushed up' and they were told to be quiet.

There had been no public consultation over this issue and he believed that he had witnessed quite possibly, the worst mishandling of a public service matter in a very long while. The public perceived that matters had occurred which were not only unsatisfactory, but distinctly underhand and he believed that a public inquiry should be held examining this whole issue. The Freedom of Information Act should easily reveal exactly what had occurred in respect of this astonishing decision and subsequent
revelations. He invited Cornwall Council to join in his call for an inquiry into the circumstances surrounding the closure of Cardrew Health Centre.

QUESTIONS FROM MEMBERS TO THE PORTFOLIO HOLDERS
(Agency No. 7)

HASCOSC6 There were no questions from Members to the Portfolio Holders.

IMPROVEMENTS TO URGENT CARE IN CAMBORNE REDRUTH COMMUNITY HOSPITAL AND CLOSURE OF CARDREW HEALTH CENTRE
(Agency No. 8)

HASCOSC7 A presentation was made to the Committee from NHS Kernow CCG and NHS England. Reference was made to the NHS’ policy direction in which it stated a strong position of simplifying urgent and emergency care services. The intention was to integrate all such services and create urgent care centres which provided greater services than Minor Injuries Units but were not full emergency departments. It was considered that this proposal would not only meet the national policy direction but also address public feedback on services and improve the sustainability and resilience of services. Reference was made and an apology given on how the news about the change had been communicated via a leak to the local media, which had also provided some misinformation. Assurance was given that the resources currently used at Cardrew would be reinvested into local services. However, there was a need to streamline what was available and to address confusion for patients. It was also explained that NHS England was not able to consult on the end of the contract or offer the status quo. However there were opportunities to engage on the improvements to service. It was therefore an engagement, rather than consultation process.

During discussion a number of issues were raised, including:

i. The view was expressed that the Cardrew Health Centre provided an excellent service, although it was unfortunate that there was no pharmacy there. It was confirmed that pharmacy provision would be considered in the new arrangements.

ii. Concern was expressed about the capacity of GPs in the area to accommodate the 3,200 patients currently the responsibility of Cardrew and of the difficulties that patients might experience in registering elsewhere. Reassurance was given that there would be support for any patient who had difficulties registering elsewhere. Reference was made to the fact that all but one of the local surgeries had space for new patients. Surgeries in the local area had been advised of the situation and some had carried out additional recruitment in preparation for increased patient numbers.

iii. A Business Case would be put together to increase the staff at Barncoose as there was recognition of pressures at local surgeries.
A joined up IT system would assist this as there were likely to be more appointments available for routine tasks.

iv. Reference was made to the fact that the registered list at Cardrew was seen as good but, in fact, the service there was not comparable with other surgeries as they did not carry out home visits etc.

v. Concern was expressed that there had been a lack of consultation because the news of the change had been leaked. Elected Members had also not been given warning, also finding out via the leak. There should have been consultation pre-decision rather than post decision, particularly as it was known that the contract was coming to an end. In response, the earlier apology was reiterated and the Committee advised that an announcement had been planned on the in principle decisions by NHS England and the CCG but the leak had prevented this from being the case. It was confirmed that the plan had been to notify patients and stakeholders all at the time. However due to the leak this process had had to be accelerated and information had come out in an ad hoc way. It was acknowledged that this was a lesson learned for the future.

vi. It was not possible to consult as there was no option to maintain the existing provision as the contract could not be extended further. Further it was not appropriate to tender for new practice for the 3,200 patients.

vii. Clarity was sought on parking provision at Barncoose and its ability to cater for an increase in patients.

viii. It was confirmed that there was a national rate for patients on the registered list and this money followed the patient. The movement of 3,200 patients would therefore make other local surgeries more viable. The other money currently invested at Cardrew would be used by the CCG for the Urgent Care Centre. Details of the costs could be provided in due course.

ix. In terms of the refinement of the new contract, it was confirmed that feedback was being received and this would be looked at in the detailed planning stage.

x. Comparisons were made with the process for the creation of the St Austell ‘super’ practice. This had happened very suddenly due to one of the GP surgeries going bankrupt and was a situation that NHS England and the CCG were seeking to avoid in Camborne and Redruth.

xi. In future, decisions may need to be made about the location of Urgent Care Centres but this would be once an assessment of how the Centre in Camborne/Redruth worked had been made.

xii. NHS England and the CCG were keen to work with local Members and stakeholders in a steering group arrangement to consider how the Urgent Care Centre could link with accident and emergency provision.

xiii. It was considered that the new arrangement would reduce the number of patients referred from Barncoose to Treliske.

xiv. The availability of an impact assessment document was queried with the view expressed that this should have been presented to
the Committee for consideration. It was confirmed that an equality impact assessment had been carried out and that this could be shared with the Committee.

xv. It was confirmed that this was the only contract of its kind in Cornwall.

xvi. Concern was expressed that this in principle decision had been made in private with no wider involvement and it was therefore queried how many other decisions were being taken in this less than open manner. Such issues could be raised confidentially with the Committee at any time if this was necessary.

xvii. GPs used one of two software systems in terms of patient records. Access to those records would be key to the success of Barncoose.

xviii. In response to a query about the situation at St Day regarding the opening of a pharmacy, it was considered that this would not happen without the doctor’s surgery remaining in place.

xix. Patients at Cardrew did not have a registered doctor as it was run by agency staff. This meant a different service than other patients.

xx. It was queried whether the change was a substantial variation, given the range of issues raised. Although there was no legal definition of a substantial variation, local criteria were in place. There was a need for the Committee to receive further information before it could make such a decision and it would need to understand the implications of this, that is whether the process would continue, be put on hold or stopped completely.

It was moved by Councillor Parsons, seconded by Councillor Jenkin and

RESOLVED that

(a) NHS Kernow CCG and NHS England be required to provide responses to the following comments at an extraordinary meeting to be convened in the next fortnight to enable the Committee to determine whether or not the change amounts to a substantial variation:

(i) Patients informed in January 2016 resulting in an impact on patient confidence which may impact on them not using or considering the service;

(ii) No communications plan to address how patient concerns will be addressed and by whom;

(iii) No evidence of consultation with patients undertaken, with the situation being presented as a fait accompli;

(iv) No equality impact assessment – currently many users are transient and are high risk due to obesity and smoking. There have been no attempts to consult with the transient population and the impact on them has not been considered. There is a risk that the new services will not be accessible to them.

(v) Accessibility and locality for other patients has not been considered.

(vi) GP pressures to assess 3,200 new patients and their overall capacity not considered.
(vii) The overall pressure on health services has not been considered and the risk is that if the Centre closes patients will look for a simpler option and use accident and emergency services placing pressure on them.

(viii) No evidence provided that the new service will improve the health of local people.

(b) Future plans for the whole area be shared with the Committee in an attempt to ensure that a similar situation does not arise again.

ADULT CARE AND SUPPORT IMPROVEMENT PLAN
(Agenda No. 9)

HASCOSC8 The Head of Service (Adult Care and Support) advised that progress continued. Internal Audit had carried out a review and was satisfied that work could progress through service planning arrangements. Reference was made to the restructure as there was confidence that this would present an opportunity for more robust performance management. The new model was based on localities and in each area there would be teams responsible for assessment and community hospitals, working with older people and adults of working age. Staff would work from the appropriate place.

During discussion, a number of issues were raised, including:
  i. Assessment waits varied. If there was an urgent request an assessment may take place more quickly than the average of 8 weeks.
  ii. There had been success in terms of recruitment and selection as the service ‘grew its own’ staff and trained individuals up into social work roles. There remained an 18% vacancy rate across the localities which were filled with agency staff. It was hoped that permanent staff could ultimately fill the vacancies. Generally it proved harder to recruit in the west of Cornwall, largely due to distance and isolation.
  iii. There was a principal member of staff working within adult care whose responsibility was to ensure the quality of practice and assurance in relation to the work carried out by social workers. With locality working there were opportunities to align services for both adults and children to enable whole family support.
  iv. This Committee should consider the performance indicators as referenced in the Internal Audit report.
  v. There was a need for the Committee to understand the efficacy of the new arrangements in order that assurance could be sought.

It was moved by Councillor Eathorne-Gibbons, seconded by Councillor Atherton and

RESOLVED that
Health and Adult Social Care Overview and Scrutiny Committee
24 February 2016

a) That the progress on implementing improvements in the Council’s Adult Social Care Improvement Plan as set out in the report be noted.

b) That the financial position and associated service pressures and risks of the Adult Care and Support Service set out in the report be noted.

c) That the approach of carrying further actions forward through the Directorate service planning process be endorsed.

d) A further report is brought to the Committee in six months time on the impact and outcomes of the restructure.

CORNWALL DEAL - HEALTH AND SOCIAL CARE INTEGRATION
(Agenda No. 10)

HASCOSC9 The Devolution and Integration Lead introduced the report, advising the Committee that the membership of the Joint Strategic Executive Committee (JSEC) had been revised and NHS providers were now in attendance. Community and public engagement events were due to take place to enable public feedback on the proposals.

During discussion, a number of issues were raised, including:-

i. Concern was expressed about the fact that to date there had been little engagement from NHS England. This was disappointing and there was a need for meaningful engagement in the future.

ii. It was queried how views would be captured from age groups who may not attend the consultation events. Reassurance was given that the providers represented both adults and young people and this would ensure their views were heard.

iii. In developing the Joint Strategic Needs Assessment it was queried how progress was going in terms of building intelligence capacity. It was confirmed that each workstream had its own risks and capacity around data collection would be included as necessary in those risks.

iv. Provider meetings would include involvement with health charities.

v. Clinical governance was considered imperative. It was confirmed that more work was progressing as the Council took on more of such responsibilities. At this stage there was significant data gathering taking place.

vi. It was confirmed that guidance from NHS regulators required two plans. The first was an annual operating plan and the second a long term, strategic, five year plan. Part of the plan was to consider how long it would take to become financially stable and not in deficit.

vii. Concern was expressed about the financial implications of including external professional support when the Trusts were in deficit. It was confirmed that public money would not be used on external support if it could be delivered in-house. As such, regular updates
were requested for this Committee on the amount spent on consultants.

It was moved by Councillor Eathorne-Gibbons, seconded by Councillor Nicholas and

**RESOLVED** that

a) The update on progress against devolution and integration programme set out in the report be noted.

b) The engagement position of NHS England in the integration process be clarified within the next report to this Committee.

c) An extraordinary meeting of this Committee be convened, as appropriate, to enable consideration of the draft implementation plan.

**REVIEW OF SERVICES PROVIDED BY PENINSULA COMMUNITY HEALTH SINCE OCTOBER 2011**
(Agenda No. 11)

HASCOSC10 The Chief Executive of Peninsula Community Health (PCH) briefly outlined the report. Issues that had been faced included the pace of change and the underestimation of the amount of VAT to be charged. Originally when established it had been thought that staff would be lost through national wastage but, in fact, staff numbers had increased due to the amount of work. The investigation by Monitor on PCH’s finances was anticipated to be available on 31 March 2016. He also referred to the fact that PCH was the first social enterprise to have a CQC inspection. The performance statistics set out in the report were favourable but it was the financial issues which meant it was not possible to continue and it was appreciated that a social enterprise may not have been the best model. Had it been established as a charity the public may have better understood its purpose, may not have been impacted by corporate tax and would have received business rate relief.

During discussion, a number of issues were raised, including:-

i. In terms of advice on how things could work in the future, issues relating to business rates and VAT and the tax implications needed to be understood. There were also issues relating to NHS properties where there was a backlog of maintenance. These buildings would come back into local control as a result of the Deal for Cornwall.

ii. Staff were congratulated on what they had done in challenging circumstances.

It was moved by Councillor Eathorne-Gibbons, seconded by Councillor Nicholas and
RESOLVED that

a) The contents of the report be noted.

b) The significant contribution made by the staff of Peninsula Community Health since it was established in 2011 to serving the population of Cornwall and the Isles of Scilly be recognised.

c) The management and staff be complimented on their significant achievements, both operationally and financially, against a very difficult background.

CHILD AND ADOLESCENT MENTAL HEALTH
(Agenda No. 12)

HASCOSC11 The Acting Director of Public Health presented the report, stating it followed up from a previous report and provided an update on the action plan arising from the original Children and Adolescent Mental Health Service scrutiny process. Reference was also made to the fact that the JSEC had appointed a commissioning lead that was jointly funded by the Council and the CCG.

During discussion, Members expressed significant concerns that there had been no progress made on the appointment of a strategic lead and until this was addressed there was unlikely to be progress. The role of a strategic lead had been identified at the beginning of the process and would ensure there was someone to hold to account. Currently this work was being carried out alongside substantive duties and this was not appropriate.

RESOLVED that

a) the Committee is disappointed that the recommendations of the previous Committee have not moved forward in an appropriate way; and

b) a report be brought to its meeting in three months time outlining how a strategic lead for Child and Adolescent Mental Health Services will be progressed and the timescale for such an appointment.

RCHT CQC REPORT UPDATE
(Agenda No. 13)

HASCOSC12 The Chief Executive of RCHT referred to the report which referred to the unannounced CQC inspection in October 2015 where it concluded that the requirements in its previous warning notice had been met. An announced inspection had taken place in January 2016 and the outcome would be reported to this Committee.
During discussion, a number of issues were raised, including:

i. The improvement was welcomed by the Committee.

ii. The hospital remained under pressure at the front line. There had been a 12% increase in emergency department activity which was contrary to the national picture. This was considered, in part, due to the fact that there had been a reduction in out of hour centres from 11 to 5.

iii. Nationally there were problems recruiting both nursing and medical staff. The hospital was focusing on recruiting to vacant posts. It had sought nurses for specialist services from abroad with 73 offers being made to individuals in the Philippines. New graduates were also being recruited from Plymouth University.

It was moved by Councillor Mitchell, seconded by Councillor Nicholas and

RESOLVED that

a) The outcome of the unannounced inspection in October 2015 and the requirements of the 29A Warning Notice being met be noted; and

b) The completion of the full planned CQC inspection and the timescale for receipt of the draft report be noted.

The meeting ended at 3.12 pm.

[The agenda and reports relating to the items referred to above are attached to the signed copy of the Minutes].
The Health and Adult Social Care Scrutiny Committee notes the progress made to date and seeks further information from and makes suggestions to officers on the implementation of the health and social devolution workstream, as appropriate.
1. Executive summary

At the last Health and Social Care Scrutiny Committee the latest activities in the development of the business plan for devolution were presented along with an update on the due diligence work being undertaken to integrate commissioning across adults’ and children’s services. The Committee were supportive of the direction of travel and the progress being made.

Since the last Committee the membership of the Joint Strategic Executive Committee (JSEC) has been extended beyond the commissioning organisations within Cornwall and Isles of Scilly to include representatives from some of our key health provider organisations. In addition, recent guidance from NHS regulators (NHS England and NHS Improvement) has been issued on future planning (place based plans/sustainability and transformation plans - STP). The guidance expects every health and care system to come together, to create its local blueprint for accelerating its implementation of the Forward View and achieving financial sustainability. It is clear that a move from each organisation creating an independent plan, assessed and approved by separate regulators, is required, and that ‘organisation-centric’ planning will no longer be sufficient. We have incorporated this planning guidance into our current plan to produce a single plan for Cornwall. In recent weeks we have been engaging with central government and NHS England over how we progress with the devolution deal for health and social care in light of the current legal directions with NHS Kernow.

Our shared vision is being developed through multiple approaches, including a thorough engagement exercise with our population, embedding clinical leadership at all levels and facilitated sessions with the leaders within our health and social care economy and the wider public sector.

Our engagement exercise has already seen the launch of a public survey which closed on 25 March. We made this available both on-line and physically within GP surgeries and Cornwall Council operated One Stop Shops throughout Cornwall. At the time of writing this report we have already received more than 1,400 responses. Four events have been held with providers from across our health and social care economy with nine further community engagement events during March.

This report provides an update on progress generally and on the specific items described above. A presentation on the emerging themes from the stakeholder engagement events will be provided on the day.

2. Background

In July 2015 Cornwall was awarded the first rural devolution deal in the country. For Health and Social Care, the Cornwall Devolution Deal included a commitment to produce a plan which moves progressively towards integration of health and social care and improves outcomes for the people of Cornwall. This will need to deliver a financially and clinically sustainable system – with the Government, NHS England and other national partners working with NHS Kernow, Cornwall Council, the Council of the Isles of Scilly and other local partners to co-design it.
In parallel with developing the plan, work is also being undertaken to deliver the changes that need to be made as a priority. This will include:

- Our intention that the domiciliary care and care at home budget will be unified and commissioning will be led by NHS Kernow and the budget for Children’s Community services will also be unified and commissioning led by Cornwall Council. Although the appropriate bodies within the respective organisations are yet to make formal decisions relating to the stated intention, this approach is considered to be appropriate and it is essential that progress is made quickly to undertake the necessary due diligence.

- A review of the governance arrangements for an integrated system.

- Implementation of the recommended changes identified in the Public Health review.

A joint programme team has been created to take forward the co-production of the strategic plan and the delivery of the changes identified in the initial phase. Five sub-workstreams have been created to take the work in phase 1 forward – Governance, strategy, adults integrated commissioning, children’s integrated commissioning and public health. The programme is provided with direction by the JSEC.

**Progress to date**

2.1 **Governance**

Since the last Health and Social Care Scrutiny Committee meeting the membership of the JSEC has been extended beyond the commissioning organisations within Cornwall to include representatives from some of our key health provider organisations. Chief Officers from Royal Cornwall Hospital Trust, Cornwall Partnership Foundation Trust, Peninsula Community Health and the GP CIC have been invited to join the board. The JSEC is responsible for providing the strategic direction and oversight for the system change programme going forward. However, without any formal delegated powers from any of the represented institutions decisions will continue to go through respective organisational governance channels.

In addition to JSEC, an executive led steering group to provide day-to-day leadership and direction to the development of our Single Cornwall Plan has been established. Each of our key institutional partner organisations is represented within the steering group through their planning leads. The Steering Group is chaired by the Chief Executive of Cornwall Partnership Foundation Trust.

The programme continues to develop its relationship with the other themes within the devolution deal. Leads from each of the themes meet monthly to review progress and establish synergies and interdependencies.
Work has commenced to map the ‘as is’ current governance arrangements for both health and social care in preparation for a review of the existing governance framework.

2.2 Developing the strategic plan

Recent guidance from NHS regulators (NHS England and NHS Improvement) has been issued on future planning (place based plans/system transformation plans). The guidance requires us to produce two plans (1 one year operational and 5 year longer term plan) to achieve three interdependent tasks:

1. To implement the Forward View
2. To restore and maintain financial balance across commissioners and providers
3. Deliver core standards for patients.

The guidance expects every health and care system to come together, to create its local blueprint for accelerating its implementation of the Forward View and achieving financial sustainability. It is clear that a move from each organisation creating an independent plan, assessed and approved by separate regulators, is required, and that ‘organisation-centric’ planning will no longer be sufficient. The expectation is that commissioners and providers will work together to plan and deliver against these three areas, working to a common plan, financial framework, with shared risks and accountability. An assessment of the current position for Cornwall against the place-based models of care design principles was presented to JSEC on 14 January and the recommendations for the co-production of the strategic plan were approved.

The Deal recognises that not only do we need to re-shape the whole system but we need to place wellbeing at the heart of our agenda and incorporate the wider determinants of health as a key component of our future plans. This will require cooperation between partners beyond health and social care, such as local communities and the voluntary, community and social enterprise sector, giving us the opportunity to be at the forefront of public sector reform.

The cornerstone to developing our vision is the engagement with a wide range of stakeholder groups to help shape Cornwall’s plans for the future. The first wave of engagement with the public has commenced through an online and paper based survey asking local people for their health and social care priorities, how we can better help people manage their own health and wellbeing, as well as their ideas on how potential savings could be made to help under pressure budgets go further. At the point of writing this report 1400 people have already given their feedback via an on-line and paper survey.

Four open provider forum events were hosted by Cornwall Council, NHS Kernow and Healthwatch to give organisations responsible for delivering Cornwall and the Isles of Scilly’s health and social care services the opportunity to help shape the future. Over 250 people attended across the four events from a wide range of organisations – health, care, education, housing, voluntary, public and private sector organisations. We asked groups to identify the top barriers and solutions
for joining up services and wrapping services around people and communities. A summary of the findings will be presented at the next board on the 31st March.

A series of community events were held in venues across Cornwall and the Isles of Scilly between 8 March and 24 March to give local people the opportunity to find out more information and give their views.

The events took the form of drop-in sessions and question and answer public meetings. The public meetings included a range of panel members from Cornwall Council, NHS Kernow, representatives from key health partners and Healthwatch. A number of topics were posed for discussion during the drop-in sessions building on the emerging themes from the public survey including:

- What's good about health and care in Cornwall now?
- What's not good about health and care in Cornwall now?
- How can we join up services to better meet your needs?
- How can we best use the resources and local assets we have got?
- How can we help you start well, live well and age well - away from hospitalised care?
- How can we help you access the right care in the right place at the right time? i.e. GPs/doctor's surgeries, minor injuries and urgent care, operations/surgery, social care, mental health, community hospitals

In addition to the above engagement activities we have also been working with other significant stakeholder groups such as the Cornwall Executive Group and the Patient Reference Group in the shaping of the future vision of health and social care. We have used a range of tools to shape the conversation including the use of a rich picture which aims to distil the future model of health and social care in a pictorial format. A working draft of the picture is available below:
2.3 Integrated commissioning

As a first step in strengthening all elements of commissioning from strategic planning to contracting and performance management, we want to combine our resources and capability. It is intended that Cornwall Council will act as lead organisation for commissioning of community based children’s services. This intention is based on the fact Cornwall Council has existing strong links to Public Health; education services; and social care. Consequently, it is well placed to lead on children and young people getting the best start in life.

In parallel, NHS Kernow will take the lead on the commissioning of domiciliary care and care homes. This will enable a more streamlined approach to securing packages of care and placements. It will also enhance the discharge process from hospital, reducing the delays people currently experience leaving hospital.

Progress has been made bringing staff together from NHS Kernow and the council. The teams are committed to developing a new model of commissioning and identifying the transformation priorities. Over the next few weeks they will help shape the workplan for 16/17. Single leadership for these plans will be established and formalised. A Memorandum of Understanding has been developed outlining joint working arrangements between NHS Kernow and Cornwall Council.

2.4 Public Health

Under the Public Health workstream 5 priority projects are being taken forward to deliver on the changes recommended in the Public Health review conducted last year.

Governance of the public health grant - The ‘Public Health Grant’ is currently managed through Cornwall Council governance processes. The Health and Wellbeing Board currently does not have the power to make any formal decisions that bind the Council. The only way that the Board could have powers to make decisions on spend would be by change in national legislation. Central Government did consult in January of this year with regards to amending the ‘Functions and Responsibility Regulations’ to allow more executive powers to be passed to Health and Wellbeing Boards but these further powers have yet to be ceded.

Review of Healthy Lifestyle Services - Since the Public Health Review in December 2014, Public Health has experienced further reductions to the Public Health grant of £1.5 million. As a result of this new financial challenge, the Health Promotion Service is requiring to make £660K savings which represents 25% of the total £2.6 million service budget. A draft service design and structure has been developed, which is informed by the stakeholder survey results which concluded on 3rd February 2016 to test the proposed service model principles and priorities. A draft organisational structure of the Health Promotion Service is complete and has been circulated to Public Health Senior Management Team (SMT) for feedback.
Building the Intelligence Capacity and JSNA - The Joint Strategic Needs Assessment is to incorporate the whole Health and Social Care system. Scoping work has commenced as an initial task so that we can ensure there is clarity on the future scope of intelligence capacity and products.

Clinical governance – With the Council becoming responsible for more and more clinical services it is imperative that appropriate clinical governance procedures are in place. A review of existing processes in place is underway including a desktop review of literature and best practice from other areas. An audit exercise with Public Health Commissioners regarding current Clinical Governance arrangements has been completed. Discussions are underway with NHS Kernow to understand their existing processes and consider potential options for alignment. A first meeting has been held with Commercial Services to understand how the procurement and contract management toolkit can support effective clinical governance.

Make Every Contact Count – A desktop analysis of pilot programme delivery to date is underway with learning from Together for Families, Early Intervention Hub and Pioneer project to determine targeting and threshold options and the role of volunteers as agents and key workers (supporters). A learning set with the Public Health South West MECC Steering Group was held on 1 December. This project is internally dependent on the future service delivery model for Healthy Lifestyles Services, which is being developed as part of the ‘Review of the Healthy Lifestyles Services’ project.

3. Outcomes/ Outputs

The Committee are reminded that the overall ambition of Cornwall’s health and wellbeing strategy is that ‘People are able to live the lives they want to the best of their ability in their communities’. This ambition is driving our redesign of care and support in Cornwall. To deliver the ambition we also need to overcome the major issues facing our health and social care services today. Without this, the standards of care to which people are entitled as set out in the NHS Constitution and Care Act are compromised. We have also, therefore, adopted the triple aim of improving health and wellbeing, improving people’s experience of care and reducing the cost of long term care and this is already informing our strategies and change programmes.

By 2020, we want people in Cornwall to be experiencing improved quality of health and social care as a result of the right care, at the right time, in the right place. We want to have reduced health inequalities and improved healthy life expectancy. Organisations across health, social care and the voluntary sector will work collaboratively so that people experience seamless services. In order to achieve the above we need to:

- Develop new models of care with local communities and the voluntary sector key contributors to a more sustainable health and care economy, with a stronger focus on prevention
- Develop an innovative and sustainable model for joint commissioning. We will bring together the functions of commissioning across health and social
Cornwall Council

care, under a simpler governance framework, with a focus on commissioning for outcomes.
- Reconfigure the provider landscape to deliver more seamless, efficient and high quality services

At this stage of the programme we are focussed on developing a credible plan that is both financially and clinically sustainable. All partners must work together to co-develop this plan. Separate, institutional plans will no longer work or be acceptable. We are also working with all of our stakeholder groups through an extensive engagement strategy to develop our vision and shape those future plans.

4. Options available and consideration of risk

Each workstream maintains a risk register which is updated monthly and kept centrally by the programme management office. The most significant risks are monitored and managed by the JSEC. The below table provides the key risks for the programme at present.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>Capacity in the system to manage both operational demands and transformation workload</td>
<td>Additional resources have been identified and funding received to secure four new resources until the end of March 2016. Further funding needs to be identified for 16/17. Further resource has been requested for the development of the STP.</td>
</tr>
<tr>
<td>Insufficient funds available in the system to support transformation</td>
<td>Successful bid for £176,000 from the Council’s devolution fund. This only provides resource cover until April 2016. The investment required to implement the changes coming from the strategic plan will be part of the business case. £2bn funding has been made available by NHS England and will be distributed based on the quality of the Sustainability and Transformation Plans</td>
</tr>
<tr>
<td>Insufficient engagement through the development of the strategic plan will impact on the quality of the plan and the buy in to change</td>
<td>Stakeholder management and engagement plan developed to ensure thorough level of engagement throughout the planning and transformation process.</td>
</tr>
<tr>
<td>Inter-organisational cooperation or partnership is not sufficient across the system to enable the system wide changes that are required</td>
<td>• JSEC membership has been extended to include key system partners including NHS England, Council of IoS, RCHT, CPFT, PCH</td>
</tr>
</tbody>
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Page 19
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<tr>
<th>Delays in decision making due to multi-layered governance processes</th>
<th>The governance arrangements for an integrated system are being reviewed as one of the early programme priorities. In the short term we need to clarify and if appropriate enhance the authority of JSEC. Given the timescales for the completion of the STP it is likely that the programme will need to work with boards or other decision-makers from each of the partner organisations to find efficient and timely ways to have decisions made.</th>
</tr>
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<tbody>
<tr>
<td>Project tasks take longer to achieve than anticipated due to multi organisational input required</td>
<td>Actively monitor progress against plan through fortnightly programme team meeting and monthly highlight reporting.</td>
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<tr>
<td>Other transformation programmes with related objectives (Living Well, Transformation Challenge Fund, Better Care Fund) may lead to duplication of work at a time when resource is at a premium</td>
<td>Reviewing programmes with respective programme managers to look at aligning each other’s programmes and sharing resource. Proposal for other related projects to be included in highlight reporting process to JSEC.</td>
</tr>
<tr>
<td>Programme tasks take longer to achieve than anticipated due to multi organisational input required</td>
<td>• Actively monitor progress against plan through fortnightly programme team meeting and monthly highlight reporting. • JSEC membership has been extended to include key system partners including NHS England, council of IoS, RCHT, CPFT, PCH and GP CIC. • Project board in place to lead on development of Single Cornwall Plan.</td>
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**5. Proposed Way Forward**

The main priority for the programme over the next reporting period is to continue to develop the single plan for Cornwall incorporating the new elements that have resulted from the latest NHS planning guidance. NHS England have given a deadline of the end of June for plans to be submitted so the team will need to work at pace to ensure we have a credible plan for Cornwall going
Cornwall Council

forward. The engagement events described earlier in the report throughout March will support the development of this plan.

Other priorities are to work with commissioning teams to develop the 12 – 18 month work plan that supports moving towards the new model for commissioning. Whilst the ambition still remains to progress towards full delegated authority for respective organisations to take lead responsibility for the commissioning of children’s (Cornwall Council) and adults (NHS Kernow) more time is required to assess the financial and governance arrangements before any formal recommendations are brought forward for approval to proceed.

6. Implications

<table>
<thead>
<tr>
<th>Implications</th>
<th>Details and proposed measures to address</th>
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<tr>
<td>Legal/Governance</td>
<td>Although no decision is sought from the Health and Adult Social Care Scrutiny Committee, there are significant governance issues related to implementation of the health and social care devolution deal workstream. These include the correct formal decision-making routes being followed, resolving the governance arrangements for the commissioning proposals, participating bodies and forums ensuring that they operate within their powers and appropriate levels of due diligence being undertaken prior to any pooling or transfer of budgets. The report articulates further areas where work needs to be done in identifying and addressing the governance and legal issues arising from this initiative.</td>
</tr>
<tr>
<td>Financial</td>
<td>The financial implications will be determined by the strategic plan but it is safe to say that a considerable amount of resource will need to be allocated to this programme to ensure the chances of success. This may include external professional support but at this stage it is difficult to estimate what the cost might be.</td>
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<tr>
<td>Risk</td>
<td>Through the strategic planning process we will look at the risks associated with all of the options being explored. All options considered within the strategic plan will be risk assessed. The risks associated with the delivery of this initial phase of the programme are presented above.</td>
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<tr>
<td>Comprehensive Impact Assessment Implications</td>
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<tr>
<td>Equality and Diversity</td>
<td>This will be assessed during the development of the strategic plan.</td>
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<tr>
<td>Safeguarding</td>
<td>This will be assessed during the development of the</td>
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</table>
Information Management
This will be assessed during the development of the strategic plan.

Community Safety, Crime and Disorder
This will be assessed during the development of the strategic plan.

Health, Safety and Wellbeing
This will be assessed during the development of the strategic plan.

Other implications
Any that are identified during the development of the strategic plan will be reported as necessary. However, there are clearly reputational and service delivery risks if the significant efforts that are being made to deliver this element of the Devolution Deal are not delivered.

Supporting Information

Appendices
None.

Background Papers:
None.

Approval and clearance of report

All reports:

<table>
<thead>
<tr>
<th>Final report sign offs</th>
<th>This report has been cleared by OR not significant/not required</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal (if significant/required)</td>
<td>Matt Stokes</td>
<td>23/3/16</td>
</tr>
<tr>
<td>Finance Required for all reports</td>
<td>John Bloomer</td>
<td>22/03/2016</td>
</tr>
</tbody>
</table>

Cabinet/individual decision reports:

<table>
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<tr>
<th>Final report sign offs</th>
<th>This report has been cleared by</th>
<th>Date</th>
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<tbody>
<tr>
<td>Head of Service</td>
<td></td>
<td></td>
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<tr>
<td>Corporate Director</td>
<td>Trevor Doughty</td>
<td>23.03.2016</td>
</tr>
</tbody>
</table>
1.0 Purpose of Report

1.1 NHS Kernow Clinical Commissioning Group (KCCG) was placed under legal directions by NHS England (NHSE) on 11 December 2015 due to the CCG’s deteriorating financial position.

This report provides a briefing to Health Overview and Scrutiny Committee on actions being taken to achieve financial recovery.

2.0 Background

2.1 The CCG will end 2015/16 with a significant deficit of around £17.4million. This position has been managed by the use of non-recurrent money and the underlying recurrent overspending position is actually around £30m per year. Within the NHS England (NHSE) regulatory arrangements there is a requirement for CCG’s ‘pay back’ any over spend at the beginning of the following financial year. In addition, NHS England rules means the CCG has to set aside an uncommitted 1% headroom fund, and a 0.5% contingency at the start of the financial year. So if nothing changed in the CCG’s spending pattern it would end 2016/17 with a deficit of £57m (£17m pay back, recurrent underlying position of £30m, and headroom/contingency of £10m). The £22m growth funding the CCG received has been fully allocated to local providers.

2.2 The CCG must plan to return spending to within the resource allocated to it by NHS England however this will not likely be achieved in a single year. NHSE is currently requiring the CCG to achieve in-year savings in 2016/17 of 7% or £50million.

The CCG is preparing a Financial Recovery Plan which will be shared once complete. As part of the financial recovery plan the CCG will need to review all areas of commissioning expenditure, improve service efficiency through redesign, decommission services which do not sufficiently add to the health of the population, or otherwise review and change access criteria, in order to ensure that the CCG can afford to fund care for those who most need it in a sustainable way.

2.3 The CCG is addressing financial turnaround using the following framework:

**Service Redesign** – agreeing the priority care pathways and service areas that represent the best opportunity for quality and financial opportunity through the understanding of unwarranted variation. Initial priority areas include Musculoskeletal, Circulation, and Trauma and Injuries, and opportunities for improvement will cut across demand management, medicines management, provider productivity etc. When these have mobilised these areas the CCG will move on to other opportunities.
**Demand moderation** – identifying how demand on health and care services can be managed. Initial priority areas in addition to the above three areas include Continuing Health Care, better management of complex/frail patients, reshaping urgent care (NHS 111/Out of Hours integration, in-hospital patient flow and the commissioning of an urgent care centre).

**Allocative efficiencies** – building upon demand moderation, identifying opportunities to ensure budgets are allocated effectively and redress any imbalances in commissioning spend. Early opportunities include a contract review of ‘soon to expire’ contracts to ensure they represent on-going value for money, or whether the funding should be invested elsewhere or stopped altogether, and medicines optimisation to ensure cost-effective prescribing.

**Provider and commissioner productivity** - in response to the pathway changes, moderating demand and changes in spend allocation, the CCG must ensure it recognises, and with provider and Council partners, plans for a reduction in provider cost base to move the system towards financial sustainability. Opportunities identified from the Carter review, IM&T strategy, estates rationalisation and back-office integration should be harnessed.

**Repatriation** – there are still a range of patients treated outside of Cornwall, so building upon good commissioning in Mental Health and Learning Disability the CCG will look to wherever possible repatriate out of area activity for these clients and work with providers to deliver this care in county. If this is possible this will provide quality, carer and economic improvements helping service and organisation viability.

**Decommissioning** – the CCG will look to see where services commissioned do not represent relative value for money. A fuller review of our total commissioning spend is being undertaken to identify opportunities to either decommissioning services and realise financial benefits, or reallocate spend to lower cost, higher quality alternatives.

The CCG is also aware of the financial challenges felt by providers of NHS services as well as the Councils in terms of social care budgets. In order to secure the scale of savings needed across the Cornwall and Isles of Scilly health and care community we will need to undertake significant transformation of services over the next five years. Some of the mechanisms for this are already in place, for example adult community services are currently transitioning into a new service model which will enable better integration between health and care community services with acute care, mental health care, and primary care services.

However, more will need to be done including how the system responds to the challenges in the Five Year Forward View by developing the shared health and care Sustainability and Transformation Plan which must be submitted in June 2016. The committee will be aware of the current range of Council and health public and provider events as well as the survey that is underway to enable people to contribute to this.

### 3.0 Recommendation

#### 3.1

Members are asked at this stage to note the contents of this report. Further updates will be made at future meetings.
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>4.0</td>
<td><strong>Details of stakeholder engagement, including quality and patient experience impact</strong>&lt;br&gt;Stakeholders are currently being engaged as part of our joint work with partners to create a single plan for Cornwall and Isles of Scilly (The Sustainability and Transformation Plan). Any specific changes proposed as a result of any of the financial turn-around activities outlined above will be subject to appropriate engagement and formal consultation requirements, in line with national policy and recognised good practice.</td>
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<tr>
<td>5.0</td>
<td><strong>Are there any equality and human rights implications?</strong>&lt;br&gt;Any specific changes proposed will be subject to agreed equality impact assessments, as part of the evaluation and engagement processes.</td>
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<td>6.0</td>
<td><strong>Financial implications</strong>&lt;br&gt;Failure to commission services within the financial allocation made to NHS Kernow, and failure to deliver to the financial business rules outlined, is a breach of our statutory duties.</td>
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<td>7.0</td>
<td><strong>Identify any risks or issues associated with this initiative</strong>&lt;br&gt;Failure to deliver the financial turnaround in the timescales required pose significant risks, and the necessary changes also pose risks. The risks associated with any changes proposed will be subject to a full risk assessment, and communicated to stakeholders as part of the process.</td>
</tr>
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</table>
Report to: Health and Social Care Scrutiny Committee  
Subject: Improvements to Urgent Care in Camborne Redruth Community Hospital and Closure of Cardrew Health Centre  
Presented by: Andrew Abbott, NHS Kernow, Pam Smith, NHS England  
Date: 5 April 2016  
Requirement: Information  

<table>
<thead>
<tr>
<th>1.0 Situation</th>
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<tbody>
<tr>
<td>The Cornwall Health and Adult Social Care Overview and Scrutiny Committee is asked to accept the evidence and data provided in this paper and associated appendices and to support the proposals for service delivery detailed in the earlier paper (11 March 2016) that are only possible because of the ending of the contract for Cardrew Health Centre.</td>
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<tr>
<th>2.0 Background</th>
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<tr>
<td>At the extra-ordinary HOSC meeting on 11 March 2016, members requested additional information, data and evidence to assure itself of the benefits and improved services to be delivered to the local community and people of Cornwall following the ending of the contract for services at Cardrew Health Centre. The background and detailed assessment of the Cardrew Health Centre contract has been detailed in the report prepared for HOSC for the meeting on 11 March 2016. That report is at Appendix Q (Paper for Health Overview).</td>
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<tr>
<th>3.0 Assessment</th>
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<tr>
<td>The Health and Social Care Scrutiny Committee sought further information, data and evidence in the following areas:</td>
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<tr>
<td>- Registered patients:</td>
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<td>o Re-registration process</td>
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<td>o Support for vulnerable groups</td>
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<tr>
<td>o Access to other surgeries</td>
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<td>o Patient views</td>
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<td>- Walk-in patients:</td>
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<td>o Implementation timescale</td>
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<td>o Availability of pharmacy</td>
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<tr>
<td>o Available space for relocation of walk in services to Camborne Redruth Community Hospital (CRCH)</td>
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<tr>
<td>- Communication and engagement:</td>
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<tr>
<td>o Stakeholder group</td>
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<tr>
<td>o Evidence of communication with registered patients and public</td>
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<tr>
<th>4.0 Recommendation</th>
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<tr>
<td>That the Committee accept the evidence and information provided and support the on-going communication, engagement and implementation of the services that will be offered to patients on redirection of the funding from the Cardrew Health Centre contract. The table, below, lists the item and the appendix in which the information can be found.</td>
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<td>Issue</td>
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<td>Walk-in patients</td>
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<td>Task</td>
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<tr>
<td>Exit Management - Cardrew Health Centre</td>
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<td>Communications</td>
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<tr>
<td>Formal notification of intention not to renew/re-procure contract given to Primecare</td>
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<tr>
<td>Develop and implement communications plan to support exit and engage patients and stakeholders re new service delivery model</td>
</tr>
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<td>Advise staff of new service delivery model/arrangements for provision of services</td>
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<td>Advise registered patients of background to change and dispersal arrangements in writing</td>
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<td>Inform PPIG</td>
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<td>Provide information for patients at practice - in particular users of walk-in service</td>
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<td>Plan communication and support for vulnerable patients</td>
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<tr>
<td>Provide regular updates for staff in writing</td>
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<tr>
<td>Patients and governance</td>
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<tr>
<td>NHSE to run process to close list to new registrations from 4/1/16</td>
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<tr>
<td>Practice to identify vulnerable patients and work with NHSE to communicate changes and put support in place</td>
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<tr>
<td>Support patients to transfer or register elsewhere</td>
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<tr>
<td>Clinical Governance - Transfer of patient records</td>
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<td>Inform COC</td>
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<td>85</td>
</tr>
</tbody>
</table>
PMCF funded UCC Pilot

Migration of PMCF funded MIU to substantively funded Urgent care Centre

CRCH MIU

PMCF funded UCC Pilot

CRCH UCC

Development of business case

CCG decision to commission Urgent Care Centre

On-going availability of Cardrew walk-in service

Cardrew walk-in

On-going support for dispersal of registered patient list to surrounding practices

Cardrew reg pts

Patient notification / List closure

NHS E
Decision not to re-procure

NHS Kernow GB

29 Mar
24 Feb
11 Mar
5 Apr
7 Jun
5 Apr
3 May
Jun
3 May
5 Apr
7 Jun

Continuity of CRCH MIU / UCC dependent upon NON-RECURRENT PMCF funding

Decision re: UCC business case

Communications and stakeholder engagement

Establish monitoring / steering group

CRCH UCC

Go-live of CRCH Urgent Care Centre

Appendix 2

Agenda No. 9

Agenda No. 9

Closure

Closure
## High Level milestones for **registered list closure** at Cardrew Health Centre

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Due</th>
<th>Who</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>List closure in place / patients informed about decision, changes and other practices to register</td>
<td>Feb 2016</td>
<td>NHS England</td>
<td>Complete</td>
</tr>
<tr>
<td>Attend initial stakeholder groups to explain processes and answer questions</td>
<td>March 2016</td>
<td>NHS Kernow / NHS England</td>
<td>Complete</td>
</tr>
<tr>
<td>Regular review of patient deductions, and letters returned undelivered</td>
<td>April 2016</td>
<td>NHS England</td>
<td></td>
</tr>
<tr>
<td>Communication with Cardrew HC to remind all regular patients that they need to register elsewhere.</td>
<td>April 2016</td>
<td>NHS England / Cardrew HC</td>
<td></td>
</tr>
<tr>
<td>Establish Reference group to monitor progress</td>
<td>April 2016</td>
<td>NHS Kernow / NHS England</td>
<td></td>
</tr>
<tr>
<td>Second letter to registered patients sent out.</td>
<td>May 2016</td>
<td>NHS England</td>
<td></td>
</tr>
<tr>
<td>Cardrew HC to contact vulnerable patients to support registration elsewhere.</td>
<td>May 2016</td>
<td>Cardrew HC</td>
<td></td>
</tr>
<tr>
<td>Review patient deductions with Cardrew HC and encourage all staff at Health Centre to remind registered patients to register elsewhere.</td>
<td>June 2016</td>
<td>NHS England / Cardrew HC</td>
<td></td>
</tr>
<tr>
<td>Third letter to patients informing them of implications of not registering at another GP surgery by 9 August.</td>
<td>July 2016</td>
<td>NHS England</td>
<td></td>
</tr>
<tr>
<td>Ensure vulnerable patients and those with ongoing care needs have been supported to transfer to ensure continuity of care</td>
<td>July 2016</td>
<td>Cadrew HC / NHS England</td>
<td></td>
</tr>
<tr>
<td>Cardrew HC closes 9 August. Medical Records of patients who have not registered elsewhere returned by Cardrew HC to Primary Care Support</td>
<td>Aug 2016</td>
<td>NHS England</td>
<td></td>
</tr>
</tbody>
</table>
## High Level milestones for list **development of Urgent Care Centre** at CRCH

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Due</th>
<th>Who</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service users informed about planned changes</td>
<td>Feb 2016</td>
<td>NHS England</td>
<td>Complete (On-going)</td>
</tr>
<tr>
<td>Reference Group set up and survey set up to inform detailed planning of UCC from a service user perspective.</td>
<td>April 2016</td>
<td>NHS Kernow / NHS England</td>
<td></td>
</tr>
<tr>
<td>KCCG approval to business case ; providers asked to proceed with implementation plan and start recruitment for UCC</td>
<td>April 2016</td>
<td>NHS Kernow</td>
<td></td>
</tr>
<tr>
<td>CRCH (provider) to work with Cardrew HC to agree transition plans for walk-in service</td>
<td>April – May 2016</td>
<td>CFT / NHS Kernow / Cadrew</td>
<td></td>
</tr>
<tr>
<td>Minor works and equipment ordered, including extra car parking / items highlighted by reference group</td>
<td>May 2016</td>
<td>CFT / NHS Kernow</td>
<td></td>
</tr>
<tr>
<td>Stocktake on recruitment and arrangements if required for temporary staffing</td>
<td>June 2016</td>
<td>CFT</td>
<td></td>
</tr>
<tr>
<td>Induction and training for all staff</td>
<td>June 2016</td>
<td>CFT</td>
<td></td>
</tr>
<tr>
<td>Expansion of current operating hours/ start transfer of work</td>
<td>June 2016</td>
<td>CFT</td>
<td></td>
</tr>
<tr>
<td>Publicity re new service</td>
<td>June –July 2016</td>
<td>CFT / NHS Kernow</td>
<td></td>
</tr>
<tr>
<td>Proposed ‘soft’ go live for UCC -service to be fully operational</td>
<td>July 2016</td>
<td>CFT</td>
<td></td>
</tr>
<tr>
<td>Cardrew HC to close walk –in service during evenings and weekends from agreed date pending full closure by end of month</td>
<td>July 2016</td>
<td>Cardrew</td>
<td></td>
</tr>
<tr>
<td>Signposting at Cardrew HC telling people service is closed and location of UCC</td>
<td>Aug 2016</td>
<td>CFT</td>
<td></td>
</tr>
</tbody>
</table>
Dear Dr Whiteley,

I am writing in reference to the Gypsy & Traveller community we work with. I have been supporting many families on the Wheal Jewel and Boscarn Parc sites for many years and would like it to be recognised the outstanding outcomes we have had with health in particular, which has happened due to the service your practise gives. Many of my clients on both sites are patients and the communication, understanding and support my clients receive has made a huge difference to their health and wellbeing. They feel very comfortable when coming into the surgeries and are able to speak about health issues without feeling anxious or frightened. They feel they are listened to and are confident they will get the help they require. They have said all doctors, nurses and reception staff explain things in a way they understand and gives time for them to talk about health issues and worries, which they have not always had elsewhere and this in turn makes them feel at ease. I feel the practise and myself work very well together to arrange appointments and make sure the patients are aware of these as most don’t read or write and many have learning difficulties. Many have never been registered with a G.P. surgery in the past and would go to the nearest A&E if they felt unwell. I am pleased to say for the first time in twenty five years everyone on both sites are now registered have access to a doctor, nurses, health visitors and midwives. This has made a huge difference to their health now and I’m sure the benefits will show even more so in the future. Many families who have left the area return due to the fact they feel they can get better health care here than they can receive elsewhere and they now recognise the importance of this. I would like to thank everyone on behalf of my clients and myself at the St. Day and Homecroft surgeries for the fantastic work with my client group as we feel you really do go the extra mile in giving an outstanding service which the families are very happy with, and for the joint multi agency working which means we can support families in a way that meets their needs. Looking at statistics nationally for Gypsy & Traveller health we are now very much at the very top end of the scale, this does show very clearly the issues of premature death, miscarriages, stillbirth and general health, which are extremely high within the Gypsy & Traveller community are much, much lower here as we have an excellent health care system. I feel this should be celebrated and the work you do must be recognised. Again a huge thank you for all the hard work, care patience and understanding given to the families.

Many Regards

Pam Hardman

Gypsy & Traveller support service

Housing Services

Cornwall Housing

07854559117

Pamela.Hardman@cornwallhousing.org.uk
Appendix D: Chacewater Statement

Statement from Chacewater Practice – Supporting Vulnerable Groups

As a Practice we have a great deal of experience in managing the health of patients who reside at the Wheal Jewell traveller community, we currently have approximately 40 patients registered with us from Wheal Jewell. Many of them make appointments to be seen in advance, but they often will walk-in and request to be seen immediately, we understand the differences in their health care seeking behaviour and work hard to accommodate this.

Of this number a large proportion are parents and children, we have regular contact with the named health visitor for Wheal Jewell, in the form of meetings and phone conversations. We are also in contact with the Wheal Jewell support liaison officer. We have a robust Safeguarding policy for all of our patients, and we have ensured that the potential safeguarding risks within a traveller community are catered for.

With this in mind, in anticipation of the Cardrew closure we have taken a number of steps to minimise the risk of these families being un-registered. We have contacted the health visitor team and WJ support liaison officer to discuss their role in encouraging registration with a local practice.

We work with the health visitors to ensure immunisation schedules are met and provide the same level of chronic disease monitoring, QOF targets and home visits to this group.

Date: 24.03.2016

Signed: S Y Gunn

On Behalf of Dr J A R Bolton & Partners
Appendix E: Primary Care in North Kerrier

Cardrew Briefing Paper (NHS England) (March 2016)

Capacity of GP Practices to register Cardrew Patients

Following approaches to all the practices in the area closest to Cardrew, all practices confirmed that they had the capacity to register more patients. The exception is Phoenix Surgery (in Camborne), which has a list closure until 1st September 2016. Many practices were enthusiastic about registering new patients as it helps the practice maintain their services. It is important to note that there will be no loss of investment to the local health economy as the funding follows the patients.

When Cardrew Health Centre was established its ‘practice area’ was the whole of Cornwall. The majority of patients registered at Cardrew do live in the Redruth, Pool and Camborne area, however a number of patients do live some distance away. The map on page 6 demonstrates the geographic spread of the Cardrew registered patients in 2015.

Almost all patients registered at Cardrew Health Centre will have the choice of a number of GP surgeries with which to register. Furthermore, since 2015, patients can now request to be ‘out of area’ registered patients, if they are clinically suitable. This means that for some Cardrew-registered patients, who perhaps work in Penzance or Bodmin, they will be able to register with GP surgeries in those areas instead.

Access to GP Services

The National GP Survey results for those practices located closest to Cardrew Health Centre are shown in the table, below.1

<table>
<thead>
<tr>
<th></th>
<th>% Easy to get through on phone</th>
<th>% Satisfied with opening hours</th>
<th>%Experience of making an appointment was good</th>
<th>% Able to get an appointment or speak to someone last time tried</th>
<th>% overall experience of surgery is good</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>73</td>
<td>75</td>
<td>73</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Kernow CCG</td>
<td>81</td>
<td>79</td>
<td>81</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>Cardrew HC</td>
<td>100</td>
<td>96</td>
<td>93</td>
<td>87</td>
<td>91</td>
</tr>
<tr>
<td>Chacewater</td>
<td>96</td>
<td>90</td>
<td>90</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>Clinton Road</td>
<td>97</td>
<td>84</td>
<td>81</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td>Harris Memorial</td>
<td>95</td>
<td>85</td>
<td>93</td>
<td>91</td>
<td>96</td>
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</table>

1 Similar data from the Public Health Observatory (publicly available, online) is also available.
This survey took place prior to the merger of Homecroft with Pool Health Centre to create Carn to Coast Health Centres. The survey results show a range of experience across the practices, many in excess of the national and Kernow CCG average.

Each year all GP Practices in England complete a contract compliance declaration, in which the practices are obliged to review their organisation and confirm that they fully comply with contractual and statutory obligations. From the 2015 declaration all GP practices in Cornwall confirmed compliance with the following statements:

The practice can evidence and make available the needs analysis and risk assessment it has used for deciding sufficient staff levels. Recognising the need to have the right knowledge, experience, qualifications and skills for the purpose of providing services in the practice and demonstrating capacity to respond to unexpected service changes.

The premises used for the provision of services under the contract are suitable for the delivery of those services and sufficient to meet the reasonable needs of the practice’s patients, and must meet Minimum Standards as defined in Schedule 1 of the Premises Costs Directions (2013). During the preceding 12 months, the practice can confirm, that it can evidence (if requested), how it is meeting the reasonable needs of its patient population and the practice has arrangements in place for its patients to access such services throughout the core hours (08:00 - 18:30 Monday to Friday) in case of emergency?

The practice can confirm it has arrangements in place for its patients to access essential services in case of emergency if the practice is not open during core contract hours.

Does the practice have at least one consulting room which is accessible to wheel chair users?

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2 Homecroft and Pool Surgeries are now known as ‘Carn to Coast Health Centres’.
Appointment systems vary from GP Surgery to GP Surgery. All offer a mixture of same day and bookable appointments. There is also the facility for a telephone consultation, where a GP and patient can speak on the telephone and decide whether it is necessary for the GP to see the patient face to face, in the home or at the surgery.

All GP surgeries in the area have systems in place which ensure that if a patient contacts the surgery during core hours, 8.00am to 6.30pm with an urgent medical problem the practice will contact that patient and if necessary will see the patient.

However the waiting time for a routine GP appointment will vary from the same day to a week or more, depending on which GP the patient wants to see and the GP’s availability.

Some practices have employed additionally trained nurses who are Nurse Practitioners or Nurse Prescribers, who run acute clinics in GP surgeries. These experienced and highly trained nurses can deal with many health problems and know when it is necessary to seek the advice of the GP for a patient. Practice Nurses provide the majority of the routine chronic disease management clinics and ongoing support to patients and their families with these conditions.

In addition to the service provided in core contractual hours (8.00am to 6.30pm) NHS England commissions an ‘extended hours access service’. This means that patients can been seen outside of the core hours. The amount of appointments varies according to the size of the practice, but in many cases GPs, practice nurses, and phlebotomists all work at these times for the convenience of patients.

The table below shows the current extended hours access service by practice (North Kerrier practices plus Chacewater).

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<thead>
<tr>
<th>Practice</th>
<th>Mon</th>
<th>Tues</th>
<th>Weds</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chacewater</td>
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<td>8:30–11:30</td>
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<tr>
<td>Clinton Road</td>
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<tr>
<td>Harris Memorial</td>
<td></td>
<td></td>
<td>18:30–21:00</td>
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</tr>
<tr>
<td>Homecroft</td>
<td>7:30–8:00</td>
<td>7:30–8:00</td>
<td>7:30–8:00</td>
<td>7:30–8:00</td>
<td></td>
<td>7:30–8:00</td>
<td></td>
</tr>
<tr>
<td>Manor</td>
<td>7:20–8:00</td>
<td>18:30–19:30</td>
<td>7:20–8:00</td>
<td>7:20–8:00</td>
<td></td>
<td>7:30–8:00</td>
<td></td>
</tr>
<tr>
<td>Mon</td>
<td>Tues</td>
<td>Weds</td>
<td>Thurs</td>
<td>Fri</td>
<td>Sat</td>
<td>Notes</td>
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<tr>
<td>18:30-19:30</td>
<td>18:30-19:30</td>
<td>18:30-19:00</td>
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</tr>
</tbody>
</table>

Phoenix

Pool

Praze

Trevithick

Veor

18:30-20:15

18:30-20:15

18:30-20:00

18:30-19:00

7:00-8:00

It can be seen that some patients have access to services from as early as 7.20am to as late as 9.00pm during the week.

All GP Surgeries in England, including those in this area and Cornwall as a whole are required contractually to provide the following online access to patients:

- Booking appointments
- Repeat prescription requests
- Access to coded medical records by 31\textsuperscript{st} March 2016, (some clinical system suppliers have not yet made this function available to practices.)

Furthermore, with the electronic prescription service, patients can order on line and then the practice can send the prescription to the community pharmacy that the patient has requested so that the patient can collect their medicine directly from the chemist. All practices require 48 hours notice for a repeat prescription for patient safety reasons (because a clinician needs to review the patient’s request and sign the script).

**Information about the physical accessibility of GP Surgeries in the area**

All GP surgeries do have at least one GP Consulting room which is accessible to wheelchair users and many practices have invested in making their premises accessible to all patients. Automatic doors, ramps, signage which is helpful for those with limited vision and loop induction systems for patients with hearing loss are just some examples of some of the reasonable adjustments made. In addition as
practices know their patients they work with them to ensure that all patients can access and understand the services and treatments on offer.

Parking and disabled parking areas do vary from practice to practice and site to site.

Appendix 1:

Given the negative media initially about the capacity of practices in Redruth to welcome registered patients from Cardrew, Manor Surgery has stated:

Manor Surgery, Redruth. In modern, purpose built premises we offer on the day appointments or, if appropriate, telephone consultations with our clinical team for patients with an urgent medical problem. We offer face to face and telephone future bookable appointments with our GPs and practice nurses and our chronic disease patients receive exemplary care from our experienced nursing team. We have an open list and are welcoming new patients who wish to register with our practice. We are excited and look forward to working alongside the other Camborne Redruth GP surgeries at the Urgent Care Centre at Camborne Redruth Community Hospital.
### Appendix F: Practice profiles

All data extracted from General Practice Profiles 2014/15, Public Health Observatory (statistical significance relates to England not Kernow CCG average)

<table>
<thead>
<tr>
<th>Practice</th>
<th>Registered persons (NHS Kernow CCG average 8,017)</th>
<th>Age distribution</th>
<th>Deprivation</th>
<th>QOF (out of 559)</th>
<th>Ethnicity estimate (% non-white ethnic groups)</th>
<th>% satisfied with phone access (CCG 81.8%)</th>
<th>% satisfied with opening hours (CCG 79.9%)</th>
<th>% who saw/spoke to nurse or GP same or next day (CCG 58.7%)</th>
<th>% reporting good overall experience of making appointment (CCG 81.5%)</th>
<th>% with a long-standing health condition (CCG 57.4%)</th>
<th>% with caring responsibility (CCG 21.5%)</th>
<th>Working status - paid work or full-time education (CCG 55.3%)</th>
<th>Working status - unemployed (CCG 3.8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardrew</td>
<td>2,909</td>
<td>Markedly different from NHS Kernow distribution.</td>
<td>4th more deprived</td>
<td>419.6 (sig lower)</td>
<td>1.60%</td>
<td>97.3% (sig higher)</td>
<td>96.9% (sig higher)</td>
<td>70.9% (not sig higher)</td>
<td>43.4% (not sig lower)</td>
<td>16.5% (not sig lower)</td>
<td>79.4% (not sig higher)</td>
<td>3.5% (not sig lower)</td>
<td></td>
</tr>
<tr>
<td>Clinton Road</td>
<td>4,036</td>
<td>Similar to NHS Kernow distribution.</td>
<td>4th more deprived</td>
<td>516.4 (not sig lower)</td>
<td>1.60%</td>
<td>100% (sig higher)</td>
<td>88.7% (sig higher)</td>
<td>72.2% (sig higher)</td>
<td>62.3% (not sig higher)</td>
<td>18.6% (not sig lower)</td>
<td>48.9% (not sig lower)</td>
<td>4.3% (not sig lower)</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix F: Practice profiles

<table>
<thead>
<tr>
<th>Practice</th>
<th>Population</th>
<th>Distribution</th>
<th>Deprivation</th>
<th>Confidence Interval</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manor</td>
<td>11,304</td>
<td>Similar to NHS Kernow distribution.</td>
<td>4th more deprived</td>
<td>550.2 (sig higher)</td>
<td>1.50%</td>
</tr>
<tr>
<td>*Pool</td>
<td>11,792</td>
<td>Similar to NHS Kernow distribution.</td>
<td>3rd more deprived</td>
<td>559 (sig higher)</td>
<td>1.70%</td>
</tr>
<tr>
<td>*Homecroft</td>
<td>6,261</td>
<td>Similar to NHS Kernow distribution.</td>
<td>4th more deprived</td>
<td>546.8 (sig higher)</td>
<td>1.40%</td>
</tr>
<tr>
<td>Harris</td>
<td>5,225</td>
<td>Similar to NHS Kernow distribution.</td>
<td>4th more deprived</td>
<td>522.9 (not sig lower)</td>
<td>1.30%</td>
</tr>
<tr>
<td>Phoenix</td>
<td>6,005</td>
<td>Similar to NHS Kernow distribution.</td>
<td>2nd most deprived</td>
<td>546.9 (sig higher)</td>
<td>1.90%</td>
</tr>
</tbody>
</table>
### Appendix F: Practice profiles

<table>
<thead>
<tr>
<th>Practice</th>
<th>Population</th>
<th>Distribution</th>
<th>Rank</th>
<th>Deprivation</th>
<th>Percentage (sig)</th>
<th>Percentage (sig)</th>
<th>Percentage (sig)</th>
<th>Percentage (sig)</th>
<th>Percentage (sig)</th>
<th>Percentage (sig)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trewithick</td>
<td>4,530</td>
<td>Similar to NHS Kernow distribution</td>
<td>2nd most deprived</td>
<td>468.4 (sig lower)</td>
<td>2.00%</td>
<td>89.0% (sig higher)</td>
<td>77.8% (not sig higher)</td>
<td>22.0% (sig lower)</td>
<td>75.9% (not sig higher)</td>
<td>52.7% (not sig lower)</td>
<td>In italics because Chacewater is not in the North Kerrier locality.</td>
</tr>
<tr>
<td>Veor</td>
<td>7,717</td>
<td>Similar to NHS Kernow distribution</td>
<td>3rd most deprived</td>
<td>458 (sig lower)</td>
<td>1.90%</td>
<td>36.7% (sig lower)</td>
<td>71.0% (not sig lower)</td>
<td>66.1% (sig higher)</td>
<td>63.5% (not sig higher)</td>
<td>15.9% (not sig lower)</td>
<td></td>
</tr>
<tr>
<td>Praze-an-Beeble</td>
<td>5,548</td>
<td>Similar to NHS Kernow distribution</td>
<td>5th most deprived</td>
<td>558.9 (sig higher)</td>
<td>1.50%</td>
<td>86.4% (sig higher)</td>
<td>82.0% (not sig higher)</td>
<td>64.2% (not sig higher)</td>
<td>89.6% (sig higher)</td>
<td>63.3% (not sig higher)</td>
<td></td>
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<tr>
<td>Chace-water</td>
<td>5,579</td>
<td>Similar to NHS Kernow distribution</td>
<td>5th least deprived</td>
<td>555.4 (sig higher)</td>
<td>1.80%</td>
<td>95.9% (sig higher)</td>
<td>89.5% (not sig higher)</td>
<td>53.2% (not sig higher)</td>
<td>95.9% (sig higher)</td>
<td>55.5% (not sig higher)</td>
<td></td>
</tr>
</tbody>
</table>

NB. Pool Health Centre and Homecroft Surgery have now merged and are known as 'Carn to Coast'. Using the data here, their combined registered list is in the vicinity of 18,000 patients.

Chacewater is included in this table as it is also geographically close to Cardrew although not in the North Kerrier Locality.
Appendix F: Practice profiles

Observations about Cardrew (compared to the other practices listed):

- Of the practices listed, Cardrew has the lowest number of registered patients.
- Cardrew has a markedly different age distribution of registered patients compared to the practices listed, and to the Cornish average.
- Cardrew has similar deprivation to the Redruth practices. It is less deprived than the Camborne practices.
- Cardrew has similar ethnicity to the Redruth practices and is less ethnically diverse than the Camborne practices and Chacewater.
- Whilst there is a high level of satisfaction with telephone access to Cardrew, which is significantly higher than the average for England, the satisfaction rate is not the highest for the practices listed. Most practices also rate significantly higher than the average for England. Only one (Camborne) practice is significantly lower than the England average.
- Of the practices listed, Cardrew rated the highest for satisfaction with opening hours. Whilst this is significantly higher than the average for England, five other practices in this list also rate as significantly higher than the average for England.
- Three practices in the list rated significantly higher than the England average for percentage who saw/spoke to nurses or GP same or next day. Cardrew was not one of these 3 practices.
- Six practices in the list rated significantly higher than the England average for percentage who reported a good overall experience of making an appointment. Cardrew was not one of these 6 practices.
- Of the practices listed, Cardrew had the lowest percentage of patients with a long-standing health condition. However, all practices in the list have a similar percentage of patients with a long-standing health condition, with these percentages not being significantly different to the average for England.
- Although not significantly different to the England average for the percentage of patients in paid work or full-time education, Cardrew has the highest percentage of the North Kerrier practices and Chacewater.
This inset map shows the full extent of Cardrew Health Centre practice boundary. The main map shows an area more local to the surgery which contains 97% of patients.
This inset map shows the full extent of Cardrew Health Centre practice boundary and the distribution of patients at LSOA geography.

The main map shows patient distribution in the vicinity of Redruth, Pool Camborne & Truro with Practices and Branch surgeries.
This inset map shows the full extent of Cardrew Health Centre practice boundary. The main map shows the vicinity of Redruth, Pool Camborne & Truro with Practices and Branch surgeries.
This inset map shows the full extent of Cardrew Health Centre practice boundary.

The main map shows public transport bus services in the vicinity of Redruth, Pool Camborne & Truro with Practices and Branch surgeries.

Cardrew Health Centre (Y02596)

Practice Boundary and Population Spread

Population Data: 31 December 2015
Total Practice Population: 3,129
Within Contractual Boundary: 3,129 (100%)
Outside Contractual Boundary: 0 (0%)

Bus services and their frequency
An extract from Cornwall Public Transport Map accessed via:

- Hourly or better Monday to Friday daytime
- Minimum of 5 journeys Monday to Friday daytime
- 1 to 4 journeys per day or less

For timetable information visit:
http://www.firstcornwall.co.uk/timetables.shtml

GP Practice  Branch surgery
This inset map shows the full extent of Cardrew Health Centre practice boundary.

The main map shows car parks in the vicinity of Redruth, Pool Camborne & Truro with Practices and Branch surgeries.
This inset map shows the full extent of Cardrew Health Centre practice boundary.

The main map shows car parks in the vicinity of Redruth, Pool Camborne & Truro with Practices and Branch surgeries

Also shown are estimates of the percentage of households with no access to a car or van from the 2011 Census.

Population Data: 31 December 2015
Total Practice Population: 3,129
Within Contractual Boundary: 3,129 (100%)
Outside Contractual Boundary: 0 (0%)

Cardrew Health Centre (Y02596)
Practice Boundary and Population Spread

<table>
<thead>
<tr>
<th>Percentage of Households with no car</th>
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<tr>
<td>At LSOA geography</td>
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<tr>
<td>Over 40%</td>
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<tr>
<td>30 to 40%</td>
</tr>
<tr>
<td>25 to 30%</td>
</tr>
<tr>
<td>10 to 25%</td>
</tr>
<tr>
<td>Under 10%</td>
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</table>

Car parks
GP Practice
Branch surgery
Appendix H: Patient and Accessibility Information – Commentary on Slides

Page 1: Map showing the entire practice boundary (the whole of Cornwall and Scilly) as an inset and in the main map a smaller area more local to the practice which contains 97% of registered patients. The distribution of patients is shown both as points representing their home locations and population density shown by the purple shaded choropleth layer. The layer uses Lower Super Output Area (LSOA) geography.

Page 2: The same population density information as in map 1, but showing GP Practices and Branch Surgeries too. The main map uses a smaller map extent showing Redruth, Pool, Camborne and Truro and will be used in the remaining maps to aid comparison.


Page 4: Bus service information from the Cornwall Public Transport Map. The map does not line up with the other map features perfectly, but it does give an overview of the level of bus service provision- not just the connections, but the frequency of service (red is most frequent).

Page 5: Car parks from Ordnance Survey AddressBase

Page 6: This map attempts to investigate where household access to private motorised transport is low. The shaded choropleth represents the percentage of households in each LSOA census area with no access to a car or van. The national household average is approximately 25%- any areas with a greater percentage (in other words worse access to a car or van) are orange or red. Further information about this Census data can be found here: http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/2011censuskeystatisticsforenglandandwales/2012-12-11#car-or-van-availability
Draft Business case: Integrated Urgent Care Centre at Camborne Redruth Community Hospital and closure of Cardrew Health Centre

Background

The NHS England contract for services provided at Cardrew Health Centre ends on 9 August 2016. NHS England and Kernow CCG have agreed that in line with national policy and direction it would be inappropriate for a separate walk-in service to be recommissioned and instead plans to transfer funding to enable the CCG to commission an integrated Urgent Care Centre (UCC) service at Camborne Redruth Hospital (CRCH).

This business case primarily relates to the UCC and needs to be agreed by Kernow CCG to enable the transfer of resources to be finalised and implementation to proceed so that replacement services are in place well ahead of the contract end date.

NHS England and Kernow CCG have previously agreed the actions recommended in the report attached setting out the background to this business case

**NHS England will not commission a separate walk-in centre service to replace the service currently provided at Cardrew Health Centre when the contract ends in August 2016**

- NHSE to engage with local stakeholders and service users to communicate the rationale for the decision and to ensure that their needs and preferences are considered when designing the Urgent Care Centre service
- NHSE to work with Primercare to develop exit strategy for the contract so that there is a smooth transition for service users and that opportunities to retain staff affected by the decision are facilitated.
- NHSE to disaggregate the contract value related to the walk-in centre and registered list services so that the walk-in centre funding can be transferred to Kernow CCG to support the commissioning of an integrated Urgent Care Centre Service. The current walk-in centre service, and therefore associated funding, should be regarded as a County-wide resource and only a proportion of the funding will be made available for the new service at CRCH

**To proceed with plans to develop an Urgent Care Centre at Camborne Redruth Community Hospital**

- Kernow CCG to consider the report and proposed development of an Urgent Care Centre at CRCH and confirm that this is in accord with its strategic plans for urgent and emergency care.
- Kernow CCG to request current providers to continue to work together to develop a more detailed plan which sets out options for the service specification, staffing model and costs for the proposed 7 day Urgent Care Centre at CRCH. Providers are asked to develop the options working on the assumption that only existing contract revenue (excluding PMCF and including only part of Cardrew walk-in centre costs)
Appendix J: Draft Business Case UCC

will be available as the balance of funding from the Cardrew Health Centre contract will be required to support UCC development in other sites.

- The CCG will only be able to make final decisions about the Urgent Care Centre once the process to identify an interim provider to replace PCH has moved to its next stage. It is however imperative to plan at risk so that implementation can proceed at speed so that the new service is in place before August 2016. As part of the process providers are requested to identify whether there are some aspects of the new service model which can be put in place (within existing contracts) ahead of the coming winter period to improve overall resilience.

- **NHSE to agree and plan dispersal of registered list at Cardrew Health Centre**
  - Engage with service users and stakeholders to explain the background to the proposed dispersal of the registered list as a result of the planned development of the Urgent Care Centre. As part of this process to ensure that all registered patients including those in hard to reach groups are personally notified of their future choice of practice and supported to re-register before Cardrew closes
  - Agree an early date from which Cardrew Health Centre will not accept new patient registrations and support staff at the Health Centre in sign-posting patients to alternatives
  - Work with Primecare to plan and manage the change in the profile of contract income during the remaining months prior to August 2016 so that the costs of required service delivery on the Cardrew site are maintained.

The recommended actions outlined above were approved and work has progressed so that this business case can be considered by NHS England and Kernow CCG in order to finalise agreements required to support early implementation.

However data shows the service users are mainly from the North Kerrier locality and the locality currently manages demand around its capabilities. Therefore although in the longer term only a proportion of funding will be made available to the area enough must be made available initially to manage demand on a like for like service basis. Once the service is running a deeper understand of demand will allow fine tuning of the capacity required. The strategic desire to replicate the model throughout Cornwall will not reduce the initial demand given that there will be no other UCC up and running.

**The core offer to the patient/where the Urgent Care Centre fits in:**

‘Talk before you walk’: Unless it is life-threatening/you need to call 999 you should first contact your GP practice or NHS 111 who will be able to offer telephone advice or an appointment if you have become unwell or need advice about a health issue. You can also obtain on-line help and advice from NHS Choices [www.nhs.uk](http://www.nhs.uk) or from the practice web-site.
In hours (Monday –Friday 8.00 -6.30): Your GP practice will usually be the best point of contact for both urgent and routine/planned care. Where a patient believes they need to be seen on that day practices offer telephone calls and/or same day appointments. Some GP practices in the local area plan to offer some of same-day appointments at the Camborne Redruth Hospital site as part of the plans to integrate services and provide patients with a ‘one-stop shop’

Out of hours 6.30pm and 8.00 am during the week and for any time at weekends: Call NHS 111 which is in place to ensure patients can get advice or be directed to the most appropriate service to meet their needs 24/7. Where a patient needs more urgent advice or treatment NHS 111 can arrange for the patient to be transferred to the Out of Hours GP service provided by Cornwall Health or to arrange for them to attend the Urgent Care Centre.

If you have had an accident or injury in the last 48 hours you are advised to attend the Urgent Care Centre at Camborne Redruth Community Hospital as in addition to being able be seen by nurse practitioners or a doctor there are diagnostic facilities like x-ray and blood test available. If you are unsure about whether your injury will be able to be treated at the UCC please telephone NHS 111 for advice or to speak to the staff on duty at the UCC to check.

The Urgent Care Centre will also see patients who walk-in as they wish to receive advice or treatment for a health problem that they believe is urgent. All walk-in patients will be triaged (assessed) on arrival and will then be seen according to their clinical priority. Patients will be treated in accord with their clinical priority.

Service to be provided:

The UCC will replace and integrate the following services:

- Interim UCC service (11am -7.00 pm only) and nurse led minor injury unit service (8.00 am -10.00 pm) provided at CRCH. Both services are available 7 days a week and see patients who self-present including those referred by NHS 111 and Cornwall Health GP OOH service.
- Walk-in service for minor illness currently provided at Cardrew HC (8.00am -8.00pm/7 days a week). The replacement for this service must be in place by summer 2016 to enable Cardrew Health Centre to close by the contract end date 9 August 2016.
- Some on-day urgent appointments for minor illness currently provided in some local GP practices (practice opening hours Monday-Friday)

The Urgent Care Centre will have capacity to see and treat 125-150 patients a day (45,000 attendances per annum). This will be a significant increase to what is currently provided as attendances currently running at approximately 16,800 per annum. There will be a GP and a minimum of 2 nurse practitioners/nurses on duty between 8.00am and 10.00pm each day. This will bring together the current MIU/interim UCC services provided on the CRCH site and the walk-in service at Cardrew Health Centre and the business case sets out how this will be funded utilising funding from the Cardrew HC contract income.

In addition local GP practices will work towards co-location of a ‘branch-surgery’ service to provide same-day appointments for unplanned care. This will be separately staffed by the participating practices and is funded through from practice income.
Appendix J: Draft Business Case UCC

The increased volumes of patient’s will allow for on-site improved diagnostics and on-site medical expertise. This will also allow improved case management of in-patients, reducing transfers back to the acute hospital and the ability to provide increased multi-disciplinary assessment services for frail elderly patients in the local area to prevent some hospital admissions. The aim will be to provide a safe and reliable conveyance destination for frailty patients with unplanned care needs that SWAST can utilise.

Once the UCC has been established and walk-in service safely transferred from Cardrew HC it is envisaged that further developments can be taken forward to maximise system wide benefits but these are not included in the preliminary business case and in some cases may require additional investment.

- Out of Hours telephone triage and Treatment Centre – as set out above the UCC will see local OOH patients who have been triaged by Cornwall Health as needing to be seen for a face to face appointment and have been booked to be seen at the UCC. Once operational and capacity can be confirmed the UCC can develop as a pilot site to trial locality based telephone triage of all OOH calls. It is anticipated that this workload can largely be absorbed by the staffing proposed in this business case. There is no reduction in the OOH contracted provision which will remain responsible for meeting demand when there is no capacity available at the UCC to triage calls and to do all home visits necessary.

- Some locality wide services such as a shared dressing clinic, walk-in phlebotomy service or pro-active medical management of frail elderly patients including those in nursing and residential homes which will improve quality and provide increased value for money.

- Links with other Locality wide services to support urgent care such as community nursing, mental health etc. This is in line with existing plans and will ensure patients attending the urgent care centre can access an appropriate range of services but is not explicitly part of the UCC development.
THE BUSINESS CASE

Strategic:

Improving the delivery of urgent and emergency care is a key priority within the 5 Year Forward View. This states that ‘firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families.’ The proposals in this business case will enable that vision to be implemented in Camborne, Redruth and the surrounding area.

The current arrangements for accessing urgent and emergency care are confusing with no consistency in terminology, opening hours or the service on offer. The Keogh Report recommends ‘the co-location of community-based urgent care services in coordinated Urgent Care Centres. These will be locally specified to meet local need, but should consistently use the “Urgent Care Centre” name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of-hours GP services. Considering all local facilities in this way will mean that networks will need to examine the extent of duplication or gaps in service offered by all of these facilities currently. Urgent Care Centres may also be advantaged by co-location with hospital services, particularly in urban areas. Urgent Care Centres would not carry the emergency red sign, nor be considered the right place to go in a medical emergency, but would have protocols in place with the ambulance service if such events occurred.’

The proposed integrated UCC at CRCH will link in with other parts of the local system so that over time the links set out diagrammatically below can be delivered.
Appendix J: Draft Business Case UCC

As described in the diagram above the role of Primary Care in delivering an effective co-ordinated response which helps manage system demand for urgent care is also a core strategic requirement.

The 5 Year Forward View recognises the pressures faced by traditional general practice and encourages practice to collaborate to deliver a wider range of local support for patients and achieve scale benefits in terms of staffing and running costs. Practices in North Kerrier are already working closely together and some mergers have taken place or are planned to increase sustainability. The Locality wishes to develop its role as local system leader and to drive forward integration of services so that person centred care is provided to people living in the area – the joint work to deliver the urgent care centre is a first important step in delivering that strategy.

NHS England looked at the option of commissioning a stand-alone GP surgery to replace the registered list element of the Cardrew HC contract. This option is neither financially viable nor an appropriate response to the strategic direction for primary care. GP practices have confirmed that they are able to offer sufficient capacity to enable the 3129 patients affected to re-register at the practice of their choice and this process is now underway.

There is significant housing development underway and planned (circa 225 new houses each year or a total of 4,500 new homes by 2030) in the locality. This will bring future increases in demand for both urgent and primary care provision. Some local GP practices are already looking at relocation from existing premises which are either at capacity and/or unsuited to the changing needs of modern general practice and the strategic estates plan for the area will need to take account of these and requirements to improve some aspects of the community hospital site.

Economic:

The core economic arguments for the business case are that delivering the integrated solution will provide best value from NHS funding:

- A more cost effective solution than the historic Cardrew Health Centre contract in relation to both the walk-in and registered patient elements of the service
- Expected system benefits which will be capable of delivering cashable savings through reduced ED attendances and emergency admissions
- Improved space utilisation at Camborne Redruth Community Hospital with consequent reduction in overhead costs across the system
- Improved financial sustainability for GP practices in the area through receipt of additional income consequent to dispersal of Cardrew HC registered list and (where wished) involvement in delivery of the UCC service

When the original contract was put in place it was expected that Cardrew Health Centre would provide a Registered List Service for circa 1000 patients and see about 3500 WIC patients each year. Those activity figures immediately proved to be significant under-estimates. The practice has attracted a rising number of patients onto its Registered List (currently 3,129) The WIC service has also been popular with local residents and holiday makers alike with the simplicity of access (7 day x 8-8) now attracting over 25,000 patients each year. The total costs associated with the contract are in the order of £1.5 million and unit costs for the separate elements are generally above alternative provision.
Appendix J: Draft Business Case UCC

<table>
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<tr>
<th></th>
<th>Unit costs (current contract)</th>
<th>GP Primary Care (GMS total cost inc. MPIG, QOF and premises)</th>
<th>MIU (National Reference Costs )</th>
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<td>Registered List</td>
<td>£262.60 per patient/year</td>
<td>£141.00 per patient /year national average</td>
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<tr>
<td>Walk In Centre</td>
<td>&gt;3500 = £52.52 3501 -5000 = free &gt;5001 £27.78</td>
<td>GP appt = circa £25 Nurse appt= circa £15</td>
<td>Type 4 A and E attendance = £33 (no significant treatment) £41(Cat 3 or 4 treatment)</td>
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</table>

Kernow CCG in line with many other areas is seeing an apparently unrelenting increase in demand for urgent care with the consequent associated financial pressures. The CCG strategy describes a model of local Urgent Care Centres intended to provide convenient local access and which in turn would relieve pressure on the Emergency Department at RCHT.

Looking across Cornwall, patients who live in Truro have only two local options when they need urgent care; either to call the GP OOH service or to attend ED. In all other localities the community hospital MIU provides a third choice. Whilst in North Kerrier patients have the interim GP led urgent care centre service rather than a standard nurse led MIU together with the WIC provided at Cardrew Health Centre. The graphs below show the comparative access rates per 1000 patients to urgent care services for three localities; North Kerrier, Truro and Mid –Cornwall from January 2014 to February 2015. The weighted population rather than raw population has been used to reflect variation in age, deprivation and other factors. The key finding is that the overall access rate to urgent care in North Kerrier is circa 20 contacts per 1000 population higher than in other localities.

![Rate per 1,000 Weighted Reg Pop for North Kerrier](image)
Reliable comparative data for urgent care demand is not available after February 2015 due to changes in contract arrangements. However available information shows that the overall rate of demand for urgent care and pattern of demand in localities is unlikely to differ from that shown in the charts above. The new model of service introduced by Cornwall Health in 2015 reduced the numbers of OOH treatment centres from 12 down to 5. The possibility that this has increased demand for WIC, MIU or ED is currently being reviewed in a public health audit. The rate of ED attendance in Truro is double that in localities with other options available which would appear to confirm that there are some patients who could be dealt with in a lower acuity service. However if overall demand rates are to be kept as low as possible with all duplication of effort reduced a patient centred single point of access for minor to moderate illness and injuries is desirable. A simple choice supported by initial telephone triage/advice with walk-in access to an integrated service is most likely to prove effective and this is the basis for the planned services in North Kerrier.

The current combined activity levels for the current UCC at Camborne Redruth Community Hospital and walk-in access at Cardrew Health Centre is 44,000 attendances per annum (3500-4000 per month).
Appendix J: Draft Business Case UCC

Patients in North Kerrier have the highest access rate of any locality to urgent care services (combined rate for walk-in, MIU, OoH and ED) at 59.9 per month/1000 weighted population. The average rate across Cornish Localities is 40.6/1000 weighted population. The area has significant levels of health need and includes the Pengengon estate which is known to have deprivation levels in the lowest 2% in the country. It is anticipated that by bringing services together on one site that utilisation rates will reduce as there is strong anecdotal evidence of multiple presentations to the services. However for planning purposes the current levels of utilisation have been assumed as there may be some increases in demand as hours are extended and as more patients use the local service in preference to ED.

At present 750 -900 patients per month (9900 per annum) who are registered with a North Kerrier GP practice attend the Emergency Department (ED) at Royal Cornwall Hospitals (Treliske). Demand is fairly evenly spread across the week but is higher on Mondays and at weekends. There is also a higher rate of attendance during the evenings. It is anticipated that in addition to replacing the current local provision the UCC should have a positive impact on ED attendances as the UCC development means there will be a reliable and well-publicised local alternative for all but the most urgent presentations from 8.00am-10.00pm x 365 days a year. North Kerrier has the second highest annual rate of ED attendances per 1000 weighted population in Cornwall (180/1000). If the UCC only enables this to be reduced to the CCG average 158/1000 this would save 1,150 ED attendances each year and the ambition would be to reduce the rate of attendance to 120/1000 which would bring a reduction of 1500 attendances each year.

The creation of the UCC model in October 2014 has reduced the numbers of patients being referred from the MIU to ED from approximately 6% to 1.5%. The presence of GPs in the department has also reduced the number of phone calls to the ED department by the nurses thus freeing up consultant time in the ED.

Across the country where Emergency Departments are working under pressure there are increases in unplanned admission rates. The expected reduction in ED attendances should therefore help reduce the rate of unplanned admissions from the area. It is also expected that the increased capability at the UCC for example on site diagnostic testing coupled with increased local knowledge about services/access to patient information will enable a proportion of patients who are currently urgent GP admissions to be avoided.

Commercial: Proposed contract arrangements:

The planned services sit alongside existing contracts which are likely to be changed in the foreseeable future:

- New interim community services contract
- NHS 111/GP out of hours
- Expected new contract option for GP services

In order to minimise risk and disruption to current contract arrangements whilst enabling this service change to proceed and inform future service specifications the following arrangements are proposed as the basis for this business case:
Appendix J: Draft Business Case UCC

- No changes to existing contracts or any cross charging arrangements to either the community services or OOH contracts which are the primary interfaces with the UCC. The OOH activity undertaken as part of the UCC service will therefore supplement the existing contract arrangements.

- A separate ‘top-up’ contract for the UCC service covering pay and non-pay costs only. This contract would be held by Cornwall Partnership NHS Trust (CPT - the new lead provider for the community services contract). A sub-contract with a lead GP practice on behalf of the North Kerrier locality or Cornwall Health would be in place for medical cover at the UCC. This arrangement means that prescribing costs relating to patients attending the UCC will be met by NHS England (as currently is the case for walk-in centre patients at Cardrew HC) as the work will be classified as primary care.

- Cornwall Partnership NHS Trust will need to establish a sub-contract with either a lead practice on behalf of GP practices in North Kerrier locality or Cornwall Health to take responsibility for ensuring the required medical cover (8am -10pm x 365 days per annum). However if the Cornwall Health option is selected it has been agreed with them that as local GP practices are keen to deliver the service (and offer portfolio working opportunities to local doctors) practices will be able to pre-book to deliver as many of the shifts as they wish and be reimbursed by Cornwall Health at the agreed rates.

- Local GP practices offering same-day appointments in the co-located ‘branch surgery’ on the CRCH site will deliver those services as part of their existing contracts with NHS England. CPT will not charge practices for the ‘branch surgery’ facility and in return GP’s and other practice staff working on the hospital site will provide advice and support the UCC as required with no charge.

The above arrangements require providers to work together in a high trust environment and to have an ‘open-book’ relationship with commissioners but will enable the system benefits of the integrated approach to be put in place and be evaluated to inform future commissioning and service delivery specifications prior to new contracts being implemented.

**Financial:**

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<th>Increase over MIU staffing to be funded from Cardrew HC budget</th>
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<td>35 sessions per week (28 for core cover plus extra 1 session)</td>
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### Appendix J: Draft Business Case UCC

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<td></td>
<td><strong>£2,760</strong></td>
</tr>
<tr>
<td>Prescriptions issued by Lead Practice or Cornwall Health</td>
<td>Continue to charge to NHS England as per Cardrew WIC now. No facility to recharge prescriptions issued by doctors working for a provider (CPT)</td>
</tr>
<tr>
<td></td>
<td><strong>£2,984</strong></td>
</tr>
<tr>
<td>Medical and surgical supplies/consumables</td>
<td>As part of MIU budget uplifted to reflect higher volume of patients</td>
</tr>
<tr>
<td></td>
<td><strong>£2,984</strong></td>
</tr>
<tr>
<td>Near Patient Testing</td>
<td>Initial estimate costs to be confirmed</td>
</tr>
<tr>
<td></td>
<td><strong>£10,000</strong></td>
</tr>
<tr>
<td>X-ray</td>
<td>£52,567 existing separate contract in place between CCG and RCHT</td>
</tr>
<tr>
<td></td>
<td><strong>£55,056</strong></td>
</tr>
<tr>
<td>Indemnity</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£8,712</strong></td>
</tr>
<tr>
<td>Travel and Training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>600</td>
</tr>
<tr>
<td>Sub-total non-pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£25,056</strong></td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Usually 12.5% of contract value but should be negotiable at 10% or lower as a top-up contract</td>
</tr>
<tr>
<td></td>
<td><strong>£80,990</strong></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£890,890</strong></td>
</tr>
</tbody>
</table>

The figures set out above are the full year annual running costs of the proposed UCC. During the first year assuming a 1 July start date for the UCC to become fully operational the running costs will be £670,000 plus 3 months continued funding for the interim UCC (£35,000 per month). This means the total running costs in the first year will be **£775,000**.

NHS England will need to retain some funding from the Cardrew Health Centre contract to meet the costs of replacing the service for patients on the Cardrew Health Centre registered list. This will require continuing investment of 3129 (number of patients) x£141 (average cost per patient) giving a total of **£442,000**.

### Non recurrent costs:

NHS England will need to retain some of the present contract funding during the first year over and above that needed to meet the ongoing costs of the registered list. Funding will be required to meet the remainder and close down costs of the Cardrew HC contract plus the ‘double-running costs incurred as patients register elsewhere. A provisional figure of £650,000 has been set aside for this purpose and the final figure will be dependent on rate of re-registration to alternative practices between 1 February and 9 August and transition arrangements for WIC service to moving to CRCH.

Public feedback has already highlighted the need for additional parking space at busy times at CRCH and 15 additional spaces can be provided at a cost of £9,200. Evaluation of options to provide the
Near Patient Testing service is underway and it is thought that it will be preferable to lease equipment rather than purchase it. The more detailed planning stages may identify a requirement for other minor works or equipment. Therefore a total of £25,000 has been provisionally allocated for non-recurrent set-up costs including extra car parking.

Summary of financial plan assumptions:

<table>
<thead>
<tr>
<th></th>
<th>NHSE budget for Cardrew HC contract</th>
<th>NHSE 2015/16</th>
<th>Kernow CCG 2015/16</th>
<th>2016/17 onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSE budget for Cardrew Health Centre contract</td>
<td>£1,500,000</td>
<td>£500,000</td>
<td>£850,000</td>
<td>0</td>
</tr>
<tr>
<td>Registered list costs</td>
<td></td>
<td>£150,000</td>
<td></td>
<td>£442,000</td>
</tr>
<tr>
<td>UCC</td>
<td></td>
<td>775,000</td>
<td></td>
<td>£890,890</td>
</tr>
<tr>
<td>Non recurrent costs for UCC</td>
<td></td>
<td>£25,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance available to Kernow CCG</td>
<td></td>
<td>£50,000</td>
<td></td>
<td>£167,110</td>
</tr>
</tbody>
</table>

Management:

Two, separate but interlinked programme management plans, to support development of this business case and, once agreed, its implementation are in place:

- Cardrew Health Centre contract exit plan (including dispersal of registered patient list) – NHS England
- Camborne Redruth Community Hospital Urgent Care Centre development of business case and implementation plan – Kernow CCG

NHS England and Kernow CCG have separately engaged the same person to be the programme lead for the programmes of work to ensure that the key inter-dependencies are identified and managed. Timescales for development, agreement and implementation of these changes are dictated by the need to have alternative safe and effective services in place for service users prior to the Cardrew Health Centre contract end date of 9 August 2016. Therefore rather than have a separate programme board structure existing decision making arrangements within NHSE and Kernow CCG are being used to ensure the programmes of work are on track.

**NHS England - Cardrew Health Centre contract exit plan:**

Project lead reports via Head of Primary Care to Director of Commissioning. Reports for decision including relevant aspects of this business case are taken by Executive Directors Team and reported to local Commissioning Oversight Group. The relevant assurance requirements and decisions within this business case are:

- To ensure that the recommended actions agreed by the Executive Directors Team and set out at the beginning of this business case are implemented
Appendix J: Draft Business Case UCC

- To monitor the exit plan and in particular to ensure that the timelines for key decisions by Kernow CCG in relation the Urgent Care Centre are met so that the walk-in service is replaced prior to August 2016
- Continuing communication with service users and other local stakeholders about why Cardew Health Centre is closing and the rationale for the decision to disperse patients rather than tender for a new provider. This includes reassuring local people that there is sufficient local capacity in GP practices and supporting patients who need advice about the re-registration process
- Close down arrangements for the current contract including funding protection during the transition period leading up to 9 August 2016.
- Confirming agreement and the finalised value of funding to be transferred by NHS England to Kernow CCG.

Kernow CCG – Camborne Redruth Community Hospital Urgent Care Centre

Project leads reports to Director of Strategy and works closely with interested provider organisations on development of the business case and implementation plan. Reports on progress and decision to support the business case and the associated actions which flow from it will be taken by the CCG Finance Planning and Quality Committee on behalf of the Governing Body, except where reserved for Governing Body decision. The relevant assurance requirements and decisions within this business case are:

- To ensure that the recommended actions agreed by Kernow CCG and set out at the beginning of this business case are implemented
- To monitor progress on the development of the business case and implementation plan and in particular to ensure that the timelines for key decisions by Kernow CCG in relation the Urgent Care Centre are met so that the walk-in service is replaced prior to August 2016
  - By mid-March 2016 for the FPQ Committee to have considered the draft business plan, operational policy and supporting financial information in order to assure itself that sufficient progress is being made that it can confirm to NHS England that a replacement for the walk-in service at Cardrew Health Centre can be operational before the contract end date. This confirmation is also required to enable the current provider to exercise a break-clause in the lease by the end of March.
  - By end April (or earlier if achievable) to agree the business case and implementation plan in order to give the go ahead to providers to proceed with implementation and in particular to start the recruitment process for staff required to deliver the UCC service
- To agree the proposed short-term contract arrangements outlined earlier in this document together with the associated financial commitments set out in the previous section. These are designed to achieve a low risk transfer of existing services together with the opportunity for the CCG to pilot a new model of urgent care service delivery which can inform future financial planning and commissioning.

The key actions and timelines to deliver the planned changes are set out in more detail in the project plans (including current status) attached in the appendices to this report.
Appendix K: Draft Operational Policy and Staffing Structure

Integrated Urgent Care Centre at Camborne Redruth Community Hospital

Service to be provided:

The UCC will replace and integrate the following services:

- Interim UCC service (11am - 7.00 pm only) and nurse led minor injury unit service (8.00 am - 10.00 pm) provided at CRCH. Both services are available 7 days a week and see patients who self-present including those referred by NHS 111 and Cornwall Health GP OOH service.
- Walk-in service for minor illness currently provided at Cardrew HC (8.00 am - 8.00 pm/7 days a week). The replacement for this service must be in place by Summer 2016 to enable Cardrew Health Centre to close by the contract end date 9 August 2016.
- Some on-day urgent appointments for minor illness currently provided in some local GP practices (practice opening hours Monday-Friday)

The Urgent Care Centre will have capacity to see and treat 125-150 patients (45,000 attendances per annum). There will be a GP and a minimum of 2 nurse practitioners/nurses on duty between 8.00am and 10.00pm each day. This will bring together the current MIU/interim UCC services provided on the CRCH site and the walk-in service at Cardrew Health Centre and the business case sets out how this will be funded utilising funding from the Cardrew HC contract income.

In addition local GP practices will co-locate a ‘branch-surgery’ service to provide same-day appointments. This will be separately staffed by the participating practices and is funded through from practice income.

The UCC will mean there is more on-site medical cover at CRCH and this will allow improved case management of in-patients and the ability to provide increased multi-disciplinary assessment services for frail elderly patients in the local area to prevent some hospital admissions.

Once the UCC has been established and walk-in service safely transferred from Cardrew HC it is envisaged that further developments can be taken forward to maximise system wide benefits but these are not included in the preliminary business case and in some cases may require additional investment.

- Out of Hours telephone triage and Treatment Centre – as set out above the UCC will see local OOH patients who have been triaged by Cornwall Health as needing to be seen for a face to face appointment and have been booked to be seen at the UCC. Once operational and capacity can be confirmed the UCC can develop as a pilot site to trial locality based telephone triage of all OOH calls. It is anticipated that this workload can largely be absorbed by the staffing proposed in this business case. There is no reduction in the OOH contracted provision which will remain responsible for meeting demand when there is no capacity available at the UCC to triage calls and to do all home visits necessary.
- Some locality wide services such as a shared dressing clinic, walk-in phlebotomy service or pro-active medical management of frail elderly patients including those in nursing and residential homes which will improve quality and provide increased value for money
- Links with other Locality wide services to support urgent care such as community nursing, mental health etc. This is in line with existing plans and will ensure patients attending the
Appendix K: Draft Operational Policy and Staffing Structure

urgent care centre can access an appropriate range of services but is not explicitly part of the UCC development

This operational policy relates solely to the UCC and should be read alongside other operational policies for the CRCH site. All staff working in the UCC will work to the agreed policies and procedures for the CRCH site unless otherwise specified.

The core offer to the patient:

The core offer to the patient/where the Urgent Care Centre fits in:

‘Talk before you walk’: Unless it is life-threatening/you need to call 999 you should first contact your GP practice or NHS 111 who will be able to offer telephone advice or an appointment if you have become unwell or need advice about a health issue. You can also obtain on-line help and advice from NHS Choices www.nhs.uk or from the practice web-site.

In hours (Monday – Friday 8.00 – 6.30): Your GP practice will usually be the best point of contact for both urgent and routine/planned care. Where a patient believes they need to be seen on that day practices offer telephone calls and/or same day appointments. Some GP practices in the local area plan to offer some of same-day appointments at the Camborne Redruth Hospital site as part of the plans to integrate services and provide patients with a ‘one-stop shop’

Out of hours 6.30pm and 8.00 am during the week and for any time at weekends: Call NHS 111 which is in place to ensure patients can get advice or be directed to the most appropriate service to meet their needs 24/7. Where a patient needs more urgent advice or treatment NHS 111 can arrange for the patient to be transferred to the Out of Hours GP service provided by Cornwall Health or to arrange for them to attend the Urgent Care Centre.

If you have had an accident or injury in the last 48 hours you are advised to attend the Urgent Care Centre at Camborne Redruth Community Hospital as in addition to being able be seen by nurse practitioners or a doctor there are diagnostic facilities like x-ray and blood test available. If you are unsure about whether your injury will be able to be treated at the UCC please telephone NHS 111 for advice or to speak to the staff on duty at the UCC to check.

The Urgent Care Centre will also see patients who walk-in as they wish to receive advice or treatment for a health problem that they believe is urgent. All walk-in patients will be triaged (assessed) on arrival and will then be seen according to their clinical priority. Patients will be treated in accord with their clinical priority.

Opening Hours:

The Camborne Redruth Hospital Urgent Care Centre is open from 8.00am until 10.00 pm every day of the year. The same-day appointment service provided by some local GP practices which will operate alongside the UCC will be provided from Monday to Friday 8.00 – 6.30 only and patients will be booked via the practice.

Which patients can use the UCC at Camborne Redruth Hospital?
Whilst the UCC is likely to be most convenient for use by patients living in or visiting North Kerrier and surrounding areas the service is available to any patient who chooses to access the services at the site. The ambulance service will also use the UCC as a receiving site for appropriate patients (see Directory of Services appendix 1). Specific services for registered patients of GP local practices such as the same-day appointments will only be accessible for patients of those practices.

Patients with the following presentations are not suitable for referral to the UCC and are specifically excluded:

- Acute severe chest pain
- Acute severe shortness of breath
- Acute and severe abdominal pain
- Acute stroke (FAST TEST POSITIVE)
- Unconscious
- Very poorly children

**Activity Levels:**

The current combined activity levels for the current UCC at Camborne Redruth Community Hospital and walk-in access at Cardrew Health Centre is 44,000 attendances per annum (3500-4000 per month).

Patients in North Kerrier have the highest access rate of any locality to urgent care services (combined rate for walk-in, MIU, OoH and ED) at 59.9 per month/1000 weighted population. The average rate across Cornish Localities is 40.6/1000 weighted population. The difference in utilisation rates in North Kerrier is very close to the walk-in access rate for the local population. The area has significant levels of deprivation and health need however it is anticipated that by bringing services together on one site that utilisation rates will reduce as there is strong anecdotal evidence of multiple presentations to the services. However for planning purposes the current levels of utilisation have been assumed as there may be some increases in demand as hours are extended and as more patients use the local service in preference to ED.

The pattern of demand on existing services is slightly different with a greater proportion of patients using the walk-in service at weekends, perhaps due to it being longer established and better known than the UCC at CRCH. Data is not available to analyse the pattern of demand at Cardrew HC throughout the opening hours but is reported to be ‘fairly even’, it would however be expected that more patients would attend during the evening when other surgeries are closed. Demand at both the UCC and Cardrew walk-in service is higher on Mondays which is known to be a day when general practice sometimes struggles to meet on-day demand. The UCC will be planned to manage an average of 125-150 attendances each day. From the data available it is expected that it will be quieter before 10.00am and after 8.00pm. However as the key opportunities for reducing pressure on ED would appear to be on Mondays and during the evenings and at weekends it is important that the UCC targets changing patient behaviours at those times.

750-900 patients per month who are registered with a North Kerrier GP practice attend the Emergency Department (ED) at Royal Cornwall Hospitals (Treliske). Demand is fairly evenly spread across the week but is higher on Mondays and at weekends. There is also a higher rate of
Appendix K: Draft Operational Policy and Staffing Structure

Attendance during the evenings. It is anticipated that in addition to replacing the current local provision the UCC should have a positive impact on ED attendances as the UCC development means there will be a reliable and well-publicised local alternative for all but the most urgent presentations from 8.00am-10.00pm x 365 days a year.

Staffing and budget:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Banding</th>
<th>Total wte including existing MIU staffing</th>
<th>Increase over MIU staffing to be funded from Cardrew HC budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse-in-charge</td>
<td>7</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>6</td>
<td>9.0 (enables 2/3 senior nurses to be on duty)</td>
<td>3.64 wte</td>
</tr>
<tr>
<td>Staff nurse</td>
<td>5</td>
<td>1.4</td>
<td>1.4 wte</td>
</tr>
<tr>
<td>HCA’s</td>
<td>3</td>
<td>2.0</td>
<td>1 wte</td>
</tr>
<tr>
<td>admin</td>
<td>2</td>
<td>3.26</td>
<td>2.46 wte</td>
</tr>
<tr>
<td>GSA</td>
<td>1</td>
<td>0.5</td>
<td>0.25 wte</td>
</tr>
<tr>
<td>GP - UCC (Option 1 CPT sub-contract to lead practice on behalf of Locality)</td>
<td>Average of £250 per session</td>
<td>35 sessions per week (28 for core cover plus extra 1 session per day for peak demand)</td>
<td>35 sessions</td>
</tr>
<tr>
<td>Option 2 medical cover sub contracted to Cornwall Health</td>
<td>1 doctor on duty at all times cost will increase if extra cover for peak demand is agreed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reception and process on arrival:

There will be a single on site reception which is the first point of contact for the UCC for all patients attending:

- Patients attending for same day appointments booked via their GP surgery will be booked using the practice patient records system with CRCH being shown as a ‘branch surgery site’.
- Where same day capacity is fully booked local practices will have the facility to access the UCC as ‘surge capacity’. When it is necessary to access this capacity the practice should liaise with the UCC to agree when patients can be pre-booked to attend the UCC pending the development of shared access to the UCC information system. This activity will be recorded as UCC patient attendances. Patients should be told they are pre-booked and their permission sought for the UCC doctor to access their primary care record and this information should be confirmed to the UCC who will record the activity as a UCC.
Appendix K: Draft Operational Policy and Staffing Structure

attendance but record the clinical contact in the practice patient record. All North Kerrier practices will need to agree an information sharing protocol in order to achieve this.

- Where Cornwall Health has after telephone triaging a patient from a North Kerrier Locality practice the need for a face to face appointment has been identified during the operating hours of the UCC they are able to pre-book the patient into the UCC. Cornwall Health will transfer triage and other information about the patient using the Adastra system. On arrival the patients’ permission to access their primary care record will be sought by reception. The activity will be recorded as a UCC attendance but clinical records will be made in the patient record.

- Minor Injury or Walk-in patients attending the UCC will be booked in at reception using the Oceana system and this will be used to record the clinical contact. All such patients will be triaged on arrival (including being managed on a see and treat basis for minor problems) and will then be seen in accordance with their clinical priority. Summary information about the clinical contact will be sent to the patients’ registered GP practice within 24 hours.

Clinical care:

- Pre-booked patients will be seen by the GP or nurse practitioner that they have been booked to see.

- All other patients attending the UCC will be triaged by a nurse practitioner on arrival. Any diagnostic testing identified as required at that point will be organised as soon as practical and in some cases this might entail the patient receiving the immediate care needed to stabilise their condition pending the outcome of diagnostic tests. In some instances (e.g., when a non-urgent x-ray is needed at a time that the service is not available) that might result is a patient then being booked for a further attendance and treatment.

- Where appropriate the nurse practitioner triaging patients will operate a ‘see and treat’ approach for patients needing minimal input. For other patients after triage the patient will be returned to the waiting room and scheduled for care by the appropriate clinician in accordance with their clinical priority.

- The range of clinical conditions which are suitable for treatment in the UCC is shown in appendix 1 which is the Directory of Services listing.

Patients with the following presentations are not suitable for referral to the UCC and are specifically excluded:

- Acute severe chest pain
- Acute severe shortness of breath
- Acute and severe abdominal pain
- Acute stroke (FAST TEST POSITIVE)
- Unconscious
- Very poorly children

Diagnostic Services:

The UCC will be supported by the following on-site diagnostic services:
Appendix K: Draft Operational Policy and Staffing Structure

- Plain x-ray is available from 9.00 am – 8.00pm Monday to Friday and 12.00 noon – 6.00pm at weekends and bank holidays.
- Near patient testing equipment will enable clinicians working in the UCC to access a range of urgent investigations.
- These services will also be accessible to GP practices in the Locality where an urgent test is required to manage and treat a patient for example in order to avoid the likelihood of ED attendance or an acute admission.

Pharmacy Services/provision of prescribed medicines

Patients attending same-day appointments run by the local GP practices but held at CRCH (effectively a branch – surgery) will be prescribed any required medication by the GP or nurse prescriber concerned using practice prescription pads (FP10s) and those costs will be attributed to the practice.

GPs/Nurse Prescribers will need some locked storage area within their clinic rooms to keep consumables (diagnostic reagent strips and lubricating jelly etc.) These items will be provided by the practices and be funded through practice budgets.

Patient’s attending the UCC (which could be a walk-in attender or someone pre-booked via a practice or the GP OOH service) that need medication will be able to receive this via the most appropriate of the following:

- Check that the patient has a supply or can obtain of common over the counter medicines eg analgesics
- Provide with a ‘TTO pack’ (over-labelled TTO (To Take Out) packs) of short-term medication in line with the supply arrangements described for Patient Group Directives applicable to the Minor Injury service or Urgent Care Centre
- By a GP or nurse prescriber working in the UCC using an FP10

Detailed protocols will be reviewed and updated to reflect the use of non-medical prescribers and to ensure prescribing arrangements meet appropriate requirements including audit of medication issued and presenting conditions. The integrated UCC will have shared stock and costs for this are included within the budget. Arrangements will be made for top-up ordering of stock items.

Prescription pads for the UCC will be provided by NHS England which will meet the prescribing costs for patients attending the UCC as this is consistent with current arrangements for walk-in patients.

Generic FP10’s will be used by all prescribers, including non-medical prescribers working in the UCC.

Policies and Procedures:

All staff working in the UCC including the same-day GP appointments on the site will work to the policies and procedures for the CRCH site and in particular attention is drawn to the following:

- Incident and accident reporting
- Health and Safety and COSHH
- Clinical record keeping and Information Governance including the information sharing agreement between North Kerrier GP practices, Cornwall Partnership NHS Trust and Cornwall Health
Appendix K: Draft Operational Policy and Staffing Structure

- Mandatory training requirements
- Complaints management
- Clinical standards and governance

Clinical and other Indemnity:

All clinical and other risk relating to the delivery of the ‘branch surgery’ service operated by local GP practices for same-day appointments will be within the personal/practice indemnity of the member of staff providing the service.

All clinical and other risk relating to staff employed or contracted by Cornwall Partnership Trust to deliver the UCC service will be within the NHS Clinical Indemnity scheme. To ensure the most flexible use of staff to meet the need of patients attending the UCC all GP’s/practice staff working on the site will be provided with an honorary contract to indemnify them for work undertaken in the UCC/support provided to UCC staff.

Cornwall Partnership Trust will retain responsibility for the safe operation of the site and will ensure appropriate insurance cover is in place for all other risks.

Performance standards:

The UCC will at all times work to the performance standards required in the contract with commissioners and/or which are nationally set. In particular the following are explicitly noted:

- Internal/local standard to ensure that all patients attending are triaged within a maximum of 30 minutes of arrival and treated within a maximum of 2 hours
- Maximum 4 hour waiting time for patients attending the UCC as this will be reported as part of the wider ED standard
## Appendix L: Pharmacy Provision in North Kerrier

<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone</th>
<th>Monday - Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Distance from CRCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Trelowarren Street, Camborne TR14 8AA</td>
<td>01209 713134</td>
<td>0900-1730</td>
<td>0900-1730</td>
<td>Closed</td>
<td>2.8 miles</td>
</tr>
<tr>
<td>10 Commercial Street, Camborne TR14 8JY</td>
<td>01209 713194</td>
<td>0830-1330, 1400-1815</td>
<td>0830-1730</td>
<td>Closed</td>
<td>2.9 miles</td>
</tr>
<tr>
<td>40 Fore Street, Troon, TR14 9EF</td>
<td>01209 613888</td>
<td>0900-1330, 1400-1730</td>
<td>0900-1300</td>
<td>Closed</td>
<td>3.7 miles</td>
</tr>
<tr>
<td>21 Trelowarren Street, TR14 8AD</td>
<td>01209 714577</td>
<td>0900-1300, 1330-1730</td>
<td>0900-1600</td>
<td>Closed</td>
<td>2.8 miles</td>
</tr>
<tr>
<td>Pool Health Centre, Station Road, Pool TR15 3DU</td>
<td>01209 718505</td>
<td>0830-1300, 1330-1830</td>
<td>Closed</td>
<td>Closed</td>
<td>1.2 miles</td>
</tr>
<tr>
<td>84 Fore Street, Redruth TR15 2BL</td>
<td>01209 215056</td>
<td>0830-1730</td>
<td>0830-1730</td>
<td>Closed</td>
<td>0.8 miles</td>
</tr>
<tr>
<td>Manor surgery, off Chapel Street, Redruth TR15 1AU</td>
<td>01209 213600</td>
<td>0830-1300, 1400-1800</td>
<td>Closed</td>
<td>Closed</td>
<td>1.1 miles</td>
</tr>
<tr>
<td>Bassett Road, Paynters Lane End, Illogan TR16 4SS</td>
<td>01209 843856</td>
<td>0900-1800</td>
<td>0900-1300</td>
<td>Closed</td>
<td>2.4 miles</td>
</tr>
<tr>
<td>16 Chapel Street, Redruth TR15 2DB</td>
<td>01209 211056</td>
<td>0845-1745</td>
<td>0900-1200</td>
<td>Closed</td>
<td>1 mile</td>
</tr>
<tr>
<td>12 Green Lane, Redruth TR15 1JT</td>
<td>01209 215845</td>
<td>0900-1300, 1330-1730</td>
<td>0900-1300, 1330-1730</td>
<td>Closed</td>
<td>1.2 miles</td>
</tr>
<tr>
<td>72 Fore Street, Redruth TR15 2AF</td>
<td>01209 215152</td>
<td>0900-1330, 1400-1800</td>
<td>0900-1730</td>
<td>Closed</td>
<td>1.1 miles</td>
</tr>
<tr>
<td>Station Road, Carn Brea Industrial Estate, Redruth TR15 3QJ</td>
<td>01209 221447</td>
<td>Monday 0800-2230, Tuesday-Friday 0630-2230</td>
<td>0630-2200</td>
<td>1000-1600</td>
<td>1.4 miles</td>
</tr>
</tbody>
</table>
Providing a retail pharmacy on the CRCH site would be a desirable complementary development to the planned urgent care centre. The process for establishing pharmacies is regulated and an application for either or an additional pharmacy or the relocation of an existing pharmacy (potentially providing an extended hours service) would need to be compliant with those requirements. The process would also need the landlord for the hospital site (currently NHSPS) hospital letting potential providers know that subject to a licence being obtained it would be willing to lease space for a retail pharmacy to be developed. On a national basis the number of pharmacy licences being granted is expected to fall so it is more likely that an application for a relocation would be successful.
Ground Floor

Block 001

Waiting Areas x3

Areas interlinked in brake is available 6 Days a week.

Work in 7 Days a week.

Access hatching in red area available for manual

Cambridge Redruth Community Hospital - MAIN BUILDING - GROUND FLOOR

Agenda No. 9

Appendix 12
Dear Colleague

NHS England and Kernow CCG have been working together to look at the opportunity to develop integrated urgent care centre services at Camborne Redruth Community Hospital. This arises due to the end of the current contract for Cardrew Health Centre later this summer. The enclosed briefing note sets out background information about the proposed changes and we are now keen to engage with service users and local stakeholders. Pam Smith (pam.smith3@nhs.net or telephone 07990 041494) is the project lead for this development and would be pleased to discuss the proposals and/or attend one of your meetings.

We are also providing information about the proposed changes to the patients who currently use Cardrew Health Centre and seeking their feedback. This includes writing to patients who are currently registered patients at Cardrew Health Centre explaining plans and telling them that NHS England has decided to close the list to new registrations from 1 February 2016 and that if the plans are approved current patients will be asked to register with another GP practice before the current contract ends in August. A copy of that letter is also attached for your information.

We believe these exciting plans offer a great opportunity to provide patients with more co-ordinated services and in consequence to provide more care locally at Camborne Redruth Community Hospital. Letters advising registered patients about the changes will begin to go out on 1 February. Unfortunately, partial information about these changes has been leaked to local media, which means that we have no option but to work with them to present a full picture before the patient letters arrive. This is most regrettable, as our priority is always to tell the patient first.

Yours sincerely,

Julia Cory
Head of Primary Care
NHS England – South (South West)
Dear XXX

RE: Important information about the future of Cardrew Health Centre

I am writing to update you on the position at Cardrew Health Centre, where you are a registered patient.

The contract for the service is due to end in August 2016. Having already been extended to its maximum, this contract cannot be renewed.

We have thought about what to do next and considered the option of trying to find a new bidder to provide the service. However, the emphasis across the NHS now is to strengthen GP care by encouraging practices to work in bigger groups so they can share resources. With only 3,000 patients, Cardrew remains small and would be unlikely to attract much interest from potential providers or to be financially viable as a standalone surgery.

In this light, NHS England and Kernow Clinical Commissioning Group (CCG) have jointly decided that some of the money currently invested at Cardrew Health Centre should be used instead to strengthen the Urgent Care Centre at nearby Camborne and Redruth Community Hospital. It has been operating on a temporary, pilot basis since last year.

This will integrate the current walk-in service provided at Cardrew Health Centre with other local urgent care services, on a single site.

As a result, people will have permanent access to GP led care for injuries and medical conditions between 8am and 10pm every day of the week, backed by x-ray and computerised systems that gave instant access to their health records.

The move will also prevent confusion, in the light of feedback that many people don’t know where they should go if they need urgent - but not emergency - medical treatment.

You will be able to use the Urgent Care Centre, just like everybody in and around Camborne and Redruth and the wider area. However, you will also need to register with another practice for your routine GP care.
What you need to do

There is no great hurry, but you will need to re-register by August 2016 to ensure that your GP care is not interrupted.

Fortunately, there are a number of other practices in the area that have space for extra patients.

To register with another practice, you need to live within its practice boundary. You can identify where you are eligible to register and find a GP practice which meets your needs by:

- Searching ‘find GP services’ on our NHS Choices website www.nhs.uk
- Calling our NHS England Customer Care Centre on 0300 311 2233

You may also want to look at the practice websites to find out what they offer, or to phone or visit.

This is how to get in touch:

Manor Surgery – Forth Noweth, Redruth, TR15 1AU
Telephone No: 01209 313313
Practice Website: http://www.manorsurgery.co.uk/

Clinton Road Surgery – 19 Clinton Road, Redruth, TR15 2LL
Telephone No: 01209 216507
Practice Website: http://www.redruthdoctors.nhs.uk/index.aspx

Carn to Coast Health Centres – Station Road, Pool, Redruth, TR15 3DU
Telephone No: 01209 717471
Practice Website: http://www.poolhealthcentre.co.uk/index.aspx

Harris Memorial Surgery – Robartes Terrace, Illogan, Cornwall, TR16 4RX
Telephone No: 01209 842449
Practice Website: http://www.harrismemorialsurgery.co.uk/

Veor Surgery – South Terrace, Camborne, TR14 8SN
Telephone No: 01209 611199
Practice Website: http://www.veorsurgery.co.uk/

Trevithick Surgery – Bassett Road, Camborne, TR14 8TT
Telephone No: 01209 716721
Practice Website: http://www.trevithicksurgery.co.uk/

Phoenix Surgery – currently has a closed list and is unable to register new patients

Praze Surgery – School Road, Praze an Beeble, Camborne, TR14 0LB
Telephone No: 01209 831386
Practice Website: http://www.prazesurgery.co.uk/
Please contact the practice that you would like to register with to talk through the registration process. Once registered, your records will automatically transfer to your new GP practice.

If you need help in registering with a new GP practice

If you need help or experience any difficulty in registering with a new GP practice, you can contact Rachael Crawley in the NHS England South West Area Team for assistance:

- **By telephone** – call Rachael Crawley on 0113 825 1284
- **By email** – rachael.crawley@nhs.net

Yours faithfully

Julia Cory
Head of Primary Care
NHS England – South (South West)

**Accessible information**
If you need an alternative version of this letter, in large text, as audio or in another language for example, please contact Rachael Crawley.
Media release

NHS sets out plans to strengthen urgent care in Camborne and Redruth

Plans are being developed to strengthen the NHS Urgent Care Centre (UCC) at Camborne Redruth Community Hospital.

The aim is to integrate and develop the current walk-in facility at Cardrew Health Centre into the UCC that was set up on a temporary, pilot basis last year.

This would give local people and holidaymakers permanent access to GP-led care for injuries and medical conditions between 8am and 10pm every day of the week, backed by x-ray and computerised systems that give instant access to their health records, with patient consent.

The move would also prevent confusion, in the light of feedback that many people don’t know where they should go if they need urgent - but not emergency - medical treatment.

Given the proposals for the UCC, no more patients will be registered with Cardrew Health Centre from February 2016. This will avoid their having to move again in the summer, when the practice’s contract ends and all patients will need to have registered with another practice.

NHS England, which is responsible for making sure people have access to GP care, is writing to all registered patients on the current Cardrew Health Centre list to explain the position.

There are several other practices in the North Kerrier and Carrick area which together have capacity for more people to sign on.

The next stage will be for NHS England and NHS Kernow (the CCG) to work with local people to help shape the UCC. This will mean finding out what people would value from the UCC, in terms of services, staffing and access arrangements, and seeing how these might fit within national guidelines.
Linda Prosser, Director of Commissioning for NHS England in the South West, said: “It’s very clear that people don’t always know where to go if they need urgent care. By concentrating all walk-in services in this area at the community hospital, we’ll have a single urgent care centre that can cope with a wide range of injuries and illnesses and operate 14 hours a day.

“It’s fortunate that we have capacity at other nearby surgeries, which are committed to welcoming Cardrew Health Centre’s patients. We appreciate that this will cause some disruption for those patients, which is why our letter explains the process of re-registering.

“We would like to thank Nestor Primecare, and in particular the staff at Cardrew Health Centre, for their work over the years. The service has been popular with local patients and has always met or exceeded contract requirements.”

Dr Iain Chorlton, Chairman at NHS Kernow, said: “This new model of care for Cornwall is an exciting development as we reshape local healthcare to improve patient experience and outcomes and ensure that services are sustainable.

“The integration of health and social care services at the urgent care centre will provide seamless care for patients.

“No one wants to sit and wait for hours when they need care urgently and it means that patients can be seen more quickly and by the appropriate person, over extended opening hours.

“There will be wider benefits for the local system too, as this new extended service will help to ease pressure on other services such as the emergency department at Royal Cornwall Hospital.”

For more information about appropriate use of local healthcare services and their availability visit: https://www.kernowccg.nhs.uk/get-info/choose-well

Ends

Further information:

Glen Everton
NHS England
Tel: 0113 824 8770

Richard Turner
Kernow CCG
Tel: 01726 627818
Closure of Cardrew Health Centre.

Summary:

1. The Cornwall Health Overview and Scrutiny Committee is asked to support the proposals for service delivery detailed in this paper that are only possible because of the ending of the contract for Cardrew Health Centre.
2. There is a strong weight of evidence both nationally and locally that these proposals will enhance clinical and financial sustainability, and the quality of services for patients.
3. These proposals reduce the clinical and financial risk, improve the delivery of services to patients, and have robust clinical governance.
4. The proposals will generate a positive impact for service users and families and will be simpler, safer and local. Patient access will be enhanced with an increase in overall capacity and resilience because the local providers are working together.
5. The proposals improve equality of access, and there are no adverse travel implications for patients.
6. There is strong clinical support from primary care, community care and secondary care. However, we recognise that we have not yet effectively communicated the benefits of these proposals to the public. Healthwatch Cornwall has expressed its support and approval for these proposals. Engagement is now underway. We are acting on all feedback. We are committed to building and working with a stakeholder reference group.
7. The proposals have a complex rationale but are not counterintuitive. The route to this decision and recommendation may appear complex, but the way forward as proposed herein is straightforward and do-able.

Situation:

At the HOSC meeting on 24 February 2016, members requested additional information about the planned changes following the end of the contract for services at Cardrew Health Centre. This paper provides a comprehensive briefing and includes the additional information requested.

Background:

NHS England currently holds the contract for the services provided at Cardrew Health Centre. The contractor is Nestor Primecare (a private provider). The contract has two parts:

1. The primary care aspect (registered patients)
2. The walk-in aspect.

This paper will discuss each aspect in turn.

For the foreseeable future, primary care contracts will continue to be with NHS England, but the responsibility for the commissioning of walk-in, minor injury, minor illness, and urgent care services sits with the Clinical Commissioning Group (NHS Kernow).

The contract for Cardrew Health Centre terminates on 9 August 2016. It has already been extended to the maximum permissible period.
The strategic and operational landscape has changed since the Cardrew contract was awarded 7 years ago. The ending of the contract affords opportunities to develop models that make best use of the resources available whilst adapting to the changing needs and demands, for example, for the frail elderly, and aligning this with the strategic direction.

**Assessment:**

**Registered patients/primary care**

At 31 December 2015 there were 3,129 patients registered at Cardrew Health Centre. This represents 5% of the total number of patients registered in the North Kerrier practices.

The table below shows the number of patients registered at the other North Kerrier practices at 31/12/15:

<table>
<thead>
<tr>
<th>Practice</th>
<th>Registered population at 31/12/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinton Road Surgery</td>
<td>4,112</td>
</tr>
<tr>
<td>Harris Memorial Surgery</td>
<td>5,318</td>
</tr>
<tr>
<td>Carn to Coast Health Centres (Homecroft + Pool)</td>
<td>18,739</td>
</tr>
<tr>
<td>Manor Surgery</td>
<td>11,306</td>
</tr>
<tr>
<td>Phoenix Surgery</td>
<td>6,004</td>
</tr>
<tr>
<td>Praze-an-Beeble Surgery</td>
<td>5,802</td>
</tr>
<tr>
<td>Trevithick Surgery</td>
<td>4,477</td>
</tr>
<tr>
<td>Veor Surgery</td>
<td>7,626</td>
</tr>
</tbody>
</table>

The North Kerrier practices tabled above have made a commitment to work more closely together and to share resources, where appropriate, and to explore efficiencies that can be generated by working at a larger scale. Together they will oversee staffing of general practitioners at CRCH, including access to primary care/on-the-day appointments.

The registered population profile for Cardrew differs from the Cornish average for practices in that:

- There is a higher turnover of patients (15%).
- There is a slightly higher proportion of patients on Disability Living Allowance (7% compared to 6% for Cornwall as a whole).
- Only 4% of patients are aged over 65 (compared to 23% for the average GP practice in Cornwall).
- Only 1% of patients are aged over 75 (compared to 7-10% for the other North Kerrier practices).
- There are no patients living in residential or nursing homes.

There is no difference in the Cardrew registered population profile compared to other Cornish practices for:

- BME
- Deprivation indices
While there are two significant Traveller sites in the local area (Wheal Jewell, St Day and Boscarn Park, Tregajorran), service users from the Gypsy and Traveller community have tended to use the walk-in service at Cardrew rather than registering there. Chacewater practice reports that it has approximately 40 patients registered at their practice from Wheal Jewell. Chacewater practice accommodates the health seeking behaviour of this group of patients (booked appointments and walk-in).¹ Carn to Coast practices are also overtly recognised by the Gypsy and Traveller communities as being accessible and welcoming of patients, with the Gypsy and Traveller Support Service acknowledging the health gains achieved by people registering at these practices.²

The Cardrew-registered patients have access to the normal range of GP practice services, including bookable appointments (Monday–Friday 8.00am-6.30pm).

While the general practice service delivered by Nestor Primecare has met or exceeded all original contractual requirements, there are now inequities in provision to this registered population compared to the rest of Cornwall. It is not a good use of public monies to simply commission a new³ ‘stand-alone’ practice with 3,000 registered patients. A ‘stand-alone’ practice of this size would find it difficult - if not impossible - to be financially viable. GP practices – and the practices in the North Kerrier area - are working more closely together and considering – using funding from NHS England from the ‘Primary Care Development Fund’ – the arrangements that need to be in place to actually or virtually join up to deliver services, and improve their viability and sustainability.⁴ The Five Year Forward View recognises the pressures faced by traditional general practice and encourages practices to collaborate to deliver a wider range of local support for patients and achieve scale benefits in terms of staffing and running costs. Part of the future plan includes using sites/premises more effectively, which is a requirement in the ‘Sustainability and Transformation Plan’. Closing the Cardrew Health Centre means that funds used at this site can be re-channelled into services to patients. The plan to provide some primary care services from Camborne-Redruth Community Hospital (see below) creates efficiency in premises as well.

Building resilience and capacity in general practice through collaborative working will allow it to meet the need and demand expected from the housing development in the region (about 225 new houses each year – a total of 4,500 new homes by 2030).

The map below shows where the patients registered (at 31/12/15) at Cardrew Health Centre live.

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¹ Note that the walk-in aspect of the service provided at Cardrew Health Centre is more formally being moved to the developing Urgent Care Centre at Camborne Redruth Community Hospital, and discussed below.
² Letter from Pam Hardman, Gypsy & Traveller support service to Dr Matt Whiteley on 03 March 2016.
³ It would have to be a new contract as the current contract cannot be extended any further.
⁴ See the Five Year Forward View at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yf-v-web.pdf
The table below shows the number of Cardrew-registered patients living within the boundaries of individual GP practices. A patient usually lives within multiple practice boundaries and therefore has a choice of several practices. (Note that Homecroft Surgery and Pool Health Centre have merged and are now known as Carn to Coast).

<table>
<thead>
<tr>
<th>Practice code</th>
<th>Practice name</th>
<th>Number of Cardrew patients within practice boundaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>L82620</td>
<td>HARRIS MEMORIAL SURGERY</td>
<td>2886</td>
</tr>
<tr>
<td>L82024</td>
<td>CLINTON ROAD SURGERY</td>
<td>2873</td>
</tr>
<tr>
<td>L82002</td>
<td>HOMECROFT SURGERY</td>
<td>2837</td>
</tr>
<tr>
<td>L82041</td>
<td>POOL HEALTH CENTRE</td>
<td>2681</td>
</tr>
<tr>
<td>L82042</td>
<td>MANOR SURGERY</td>
<td>2235</td>
</tr>
<tr>
<td>L82014</td>
<td>TREVITHICK SURGERY</td>
<td>840</td>
</tr>
<tr>
<td>L82617</td>
<td>PHOENIX SURGERY</td>
<td>737</td>
</tr>
<tr>
<td>L82068</td>
<td>PRAZE-AN-BEEBLE SURGERY</td>
<td>566</td>
</tr>
<tr>
<td>L82015</td>
<td>CHACEWATER HEALTH CENTRE</td>
<td>565</td>
</tr>
<tr>
<td>L82044</td>
<td>VEOR SURGERY</td>
<td>450</td>
</tr>
<tr>
<td>L82006</td>
<td>PENRYN SURGERY</td>
<td>348</td>
</tr>
<tr>
<td>L82061</td>
<td>CARNON DOWNS SURGERY</td>
<td>151</td>
</tr>
<tr>
<td>L82054</td>
<td>ST.AGNES SURGERY</td>
<td>120</td>
</tr>
<tr>
<td>L82028</td>
<td>THREE SPIRES MEDICAL PRACTICE</td>
<td>96</td>
</tr>
<tr>
<td>L82001</td>
<td>LANDER MEDICAL PRACTICE</td>
<td>51</td>
</tr>
<tr>
<td>Y01050</td>
<td>ROSMELLYN SURGERY</td>
<td>47</td>
</tr>
<tr>
<td>L82036</td>
<td>BODRIGGY HEALTH CENTRE</td>
<td>37</td>
</tr>
<tr>
<td>L82038</td>
<td>CAPE CORNWALL SURGERY</td>
<td>36</td>
</tr>
<tr>
<td>L82049</td>
<td>FALMOUTH HEALTH CENTRE</td>
<td>36</td>
</tr>
<tr>
<td>L82018</td>
<td>HELSTON MEDICAL CENTRE</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Other practices with less than 30 patients within boundary</td>
<td>227</td>
</tr>
</tbody>
</table>
A number of patients have already re-registered with other practices, notably Clinton Road, Carn to Coast, Manor and Chacewater. Cardrew Health Centre has reported a de-registration to date of 700 patients.

All of the local practices support the plan to disperse the list of Cardrew-registered patients. The GPs and NHS England are considering whether there can be ‘proactive’ dispersal of the list. Apart from Phoenix, which currently has a closed list, the other practices welcome the addition of patients to their list. Because the funding for primary care moves with the patient, the addition of patients to the practice lists improves each practice’s income, enabling them to recruit any additional staff they need to meet the needs of the extra patients.

Collaborative working (described above) is ensuring that primary care staff are providing support and input to practices other than their own when required (for example, where there are GP vacancies or illness). At present this has meant that waiting times for some booked appointments is longer than anyone would wish, by working together the practices are looking at ways to improve waiting times. One area that is being explored is the possibility of a primary care service, staffed by the local practices, sitting alongside the urgent care service (see below) at Camborne Redruth Community Hospital.

The collaborative working amongst the local practices is supported by the use of new and emerging technologies and technological solutions. By being able to access and share records, with patient consent, any GP from any of the practices will be able to see and treat a patient either within a practice or on-site at Camborne Redruth Community Hospital. Such technological solutions are also an explicit requirement in the ‘Sustainability and Transformation Plan’.

Conclusion:

There are few alternatives to the proposal to disperse the Cardrew registered patient list. Options include:

A. Maintaining a stand-alone registered list of approximately 3,000 patients at a site in Cornwall.

B. Adding the complete registered list to a single practice – perhaps creating a branch surgery.

Regarding ‘A’, the Cardrew site is not owned by the practice and is not an NHS property, so there is no requirement for this site to be used for primary care in the future. The registered list at Cardrew has patients from across Cornwall (albeit mainly in North Kerrier). A primary care provider would need to explore site opportunities for a new stand-alone practice in the area. Estate in North Kerrier is already limited, and any NHS investment in properties must be in line with the overarching Estates Strategy, and Sustainability and Transformation Plan. A small practice with only 3,000 registered patients would not be financially viable, sustainable or safe, and is not in accord with the national and strategic direction of travel where practices and service providers are working closely together to share resources.

Every patient has the right to choose where to register. Regarding ‘B’, transferring the whole patient list to a single other practice does not give patients choice. Not every patient lives within the catchment of a single surgery in the locality. There are similar issues to ‘A’ about
the ability to acquire a ‘site’ for a branch surgery. A branch surgery of 3,000 patients is not financially viable at the same site. NHS England and the practices in North Kerrier considered this option but do not support it because it would destabilise the other practices in the area.

For these reasons, list dispersal (as described above) is the only viable alternative. The NHS was not in a position to discuss this information with the public earlier because of the complexity of the situation at the time and the commercially sensitive nature of some of the information. The priority was to ensure that the Cardrew registered patients and other service users at Cardrew were engaged at the same time as communicating with wider stakeholder groups.

The offer remains to patients that if they need help in re-registering with a practice convenient to them, they should contact NHS England. (This was detailed in the letter to patients).

Walk-in element and development of an Urgent Care Centre at Camborne Redruth Community Hospital

Cardrew Health Centre has provided a walk-in service 7 days a week, 8 a.m. until 8 p.m. This has overlapped with the provision of primary care services in general practice, out of hours services and minor injury/minor illness services and the pilot urgent care centre at Camborne Redruth Community Hospital.

The area has had a minor injury unit at the local community hospital (Camborne Redrut Community Hospital (CRCH)) commissioned as part of the Community Health contract by the Primary Care Trust/Clinical Commissioning Group. Since December 2013, the minor injury unit has been enhanced through non-recurrent monies from the ‘Prime Minister’s Challenge Fund’ (PMCF) and has been able to provide services akin to an ‘urgent care centre’, staffed by GPs, with other clinical support and now offering a service 7 days a week, 11 a.m. to 7 p.m. with Xray provision.

The introduction of a GP (that is, a prescriber) into the UCC meant that the DOS (directory of services) could be significantly changed to show an increased number of dispositions. The locality GPs agreed that in the best interest of patients when they had a large demand for unplanned care and same day appointments they would give their receptionist the choice of asking the patients to attend the UCC rather than come into the practice. All patients who presented to the UCC were able to access equitable treatment plans irrespective of where they were registered. The stipulation was, however, that this service was to provide patients with unplanned care needs in an acute situation. There was no offer to provide routine General Medical Services (GMS) or to provide a service for people requiring referral to outpatient services. These people were to return to their own GP.

The PMCF funding ends on 31 March 2016 and NHS England has offered to continue its funding until the Cardrew contract ends and money released from that can be moved to fund the continuation and ongoing development of the Urgent Care Centre. At this time, the contract will be between the CCG and the provider of the Urgent Care Centre service. Without this funding, the service at CRCH would have to revert to a nurse led minor injury unit, and the opportunity to provide an enhanced service to the local community of 70,000 patients (and beyond) would be lost, with the likelihood that patients would have to access
Treliske for their urgent care needs outside of the hours of primary care. (Only 1.1 to 1.8% of patients are referred to Treliske from the Urgent Care Centre, compared to between 4 and 9% of patients from the Cornish minor injury units). It would also put greater pressure on ‘in hours’ general practice which, in turn, could cause a continuation and building of difficulties in access to booked appointments.

The vision is to develop – using the walk-in element of the Cardrew contract to top up the minor injury unit provision – a fully integrated NHS Urgent Care Centre at CRCH. This will offer a 7 day, 365 days a year, urgent care service from 8 a.m. to 10.00 p.m. The opening times and services for urgent care will extend beyond those currently available at either Cardrew or the PMCF urgent care service.

The integrated service will both remove duplication but also confusion. (Cornwall Healthwatch has commented on the confusion for patients in knowing which service to access and when, often reverting to Treliske Accident and Emergency).

This development is consistent with the national strategic context and vision, and also the urgent care strategy for Cornwall and the Isles of Scilly that will be further documented in the Sustainability and Transformation Plan (STP). Improvements required to the site at CRCH will be part of the Estates Strategy, which feeds into the STP. A working group for the proposals already exists and includes members of the hospital’s League of Friends.

Improving the delivery of urgent and emergency care is a key priority within the Five Year Forward View. This states, ‘firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families.’

The current arrangements for accessing urgent and emergency care are confusing with no consistency in terminology, opening hours or the service on offer. The Keogh Report recommends ‘the co-location of community-based urgent care services in coordinated Urgent Care Centres. These will be locally specified to meet local need, but should consistently use the “Urgent Care Centre” name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of-hours GP services. Considering all local facilities in this way will mean that networks will need to examine the extent of duplication or gaps in service offered by all of these facilities currently. Urgent Care Centres may also be advantaged by co-location with hospital services, particularly in urban areas. Urgent Care Centres would not carry the emergency red sign, nor be considered the right place to go in a medical emergency, but would have protocols in place with the ambulance service if such events occurred.’

The inter-relationship between the Urgent Care Centre at CRCH and the delivery of primary care in the area (describe above) will be strengthened. As well as the proposed on the day, urgent appointments for minor illness provided by local GPs on the CRCH site, the GP presence at CRCH through the UCC will:

- Increase the medical cover on-site and allow improved case management of inpatients at CRCH and the ability to provide increased multi-disciplinary assessment services for
frail elderly patients in the local area, which are likely to prevent some hospital admissions.

- Increase the scope to provide other locality-wide services, such as a shared dressings clinic, or proactive medical management of frail elderly patients, including those in nursing and residential homes.
- Provide an opportunity to explore and develop services that reduce duplication of triage and blur the distinctions between what is ‘in hours’ and what is ‘out of hours’ provision.
- Through co-location, improve the links with other services and lead to integrated provision, for example, in community nursing and mental health.

Conclusions:

The alternatives to developing the Urgent Care Centre at Camborne Redruth Community Hospital have been considered but discounted because:

- The current contract at Cardrew has to terminate.
- It is neither desirable nor permissible to commission a ‘stand-alone’ walk in service.
- The national review and clinical evidence sets the direction of travel, which requires co-location and joining up of services and optimisation of sites to ensure clinical and financial sustainability.

The NHS believes that whilst the development of Urgent Care Centres in other areas is desirable, there should be no diminution in the level of services historically available in Camborne -Redruth, which has a high level of need.

**Recommendation:**

That the improved offer to patients afforded by ending the contract for Cardrew Health Centre be supported. Both the primary care/registered patients and walk-in elements will continue to be provided, albeit at different sites. These sites, however, remain close to people’s homes/where people reside. Through general practice in the area working together, the entire population of North Kerrier will benefit. The offer for walk-in/urgent care is greater than that currently provided, representing improved services for patients.
Report to: Health and Social Care Scrutiny Committee  
Subject: Adult Community Health Services – Edward Hain in-patient unit  
Presented by: Phil Confue CEO Cornwall Partnership NHS Foundation Trust  
Date: 23 March 2016  
Requirement: Information

### 1.0 Purpose of Report

1.1 To provide Health and Social Care Scrutiny Committee with reasons behind Peninsula Community Health’s (PCH) decision to temporarily close the in-patient unit of Edward Hain Community Hospital in St Ives from 1 March 2016.

### 2.0 Background

2.1 During late December 2015 Kendall Kingscott undertook a survey of the Edward Hain Hospital on behalf of NHS Property Services Ltd as part of an agreed programme with the Cornwall Fire and Rescue Service. This survey identified deviations from the Building Regulations and Fire code for the fire compartmentation aspect of the building.

2.2 The deviations were brought to NHS Property Service’s attention as landlord to enable it to assess and review the level of fire risk for all users of the building. The review took into account the building’s age (1920’s), current use, fire safety design and the construction methods/standards applied. The purpose of the review was to establish if opportunities for improving fire safety were available and also to look to establish if relevant regulations and nationally recognised standards are complied with in the existing management, design and construction and a comparison has been made using Regulations and the suite of Standards identified in the report.

2.3 The review found that the fire safety design and construction of the building failed to meet recognised Fire code standards; therefore alterations were required to the building to bring fire compartmentation up to a safe and compliant standard. It was also concluded that the age and standard of construction used had significantly contributed to the overall unsafe standard of the premises.

   It was deemed that the level of risk to in-patients was not acceptable due to the established reductions in fire safety identified within the Kendall Kingscott report. The patients require a high level of care and are considered to be at higher risk if there was a fire. To mitigate the level of risk to the patients, the buildings where they are cared for and sleep need to be of a high standard of fire safety to offer the protection required.

2.4 PCH was made aware of the concerns at a meeting on 10 February 2016 although the actual report from Kendall Kingscott was only made available for a meeting called by the PCH Chief Executive on Tuesday 23 February 2016. Immediate mitigation, including additional staffing at night, was put into place to minimise the risk and a further meeting was convened for 8am on Friday 26 February at Edward Hain Hospital including representatives from NHS Property Services Ltd, CHESS, PCH and Capita (representing PCH as their Fire Advisor). The chair of the Edward Hain League of Friends was also invited and attended at the beginning of the day and for a summary around lunchtime.
2.5 PCH Chief Executive informed both NHS Kernow and Cornwall Council’s Adult Social Care Portfolio Holder and Councillor Andrew Mitchell on 24 February of the concerns raised in the report, and he addressed St Ives Town Council at their monthly meeting on the evening of Thursday 25 February.

Actions agreed at the meeting at Edward Hain on 26 February were:
- Arrangements were made with each patient and family for their planned discharge over the following days.
- The already increased staffing levels at night were be maintained as long as there were in-patients.
- Edward Hain in-patient unit would close on 1 March. Day services such as out-patients appointments for podiatry would remain open.
- Seven additional beds were opened from 1 March on the previously closed Hayman Ward at Camborne Redruth Community Hospital as a short term measure to support the system over the busy winter period. Staff from Edward Hain were used to support this ward.
- Agreed communications led by NHS Property Services including comments from NHS Kernow, PCH and the League of Friends.
- All key stakeholders were informed of the PCH decision including the local MP.

3.0 Update from NHS Property Services 23 March 2016

3.1 As owner of the building, NHS Property Services (NHS PS) has appointed an approved fire engineer who will assess the site as a matter of priority in early April 2016.

NHS PS has tasked the engineer with specifying a solution to allow all the beds to be reopened however, as a priority they are also asking the engineer to propose cost-effective works that could be undertaken in a shorter timeframe to allow the 5-7 beds located to the rear of the property to be opened as soon as possible.

The scope of the works recommended by the engineer will determine the time needed to carry it out and NHS PS hope to be able to provide further details regarding timescales in due course.

All other out-patient services (on the ground floor) continue to operate as normal.

4.0 Recommendation

4.1 Members are asked at this stage to note the contents of this report. Further updates will be made at your next meeting.

5.0 Details of stakeholder engagement, including quality and patient experience impact

As outlined in the paper local stakeholders have been informed and involved in the decision made. Any future decisions will continue to involve the necessary local and statutory stakeholder groups.

6.0 Are there any equality and human rights implications?

Any substantive changes will be subject to an equality impact assessment.

7.0 Financial implications

The financial consequences of the remedial works recommended will become clear when the appointed engineer reports to NHS Property Services.

8.0 Identify any risks or issues associated with this initiative

- Failure of the building to adhere to Building Regulations and Fire code increases the safety risk that patients and staff are exposed to.
<table>
<thead>
<tr>
<th><strong>Kernow Clinical Commissioning Group</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Failure to respond appropriately to known deficiencies against Building Regulations and Fire code, puts at risks the accountable Board and Officers for the services delivered from the building, and the owners of the property.</td>
</tr>
<tr>
<td>• Ongoing closure of the inpatients beds without alternative services in place puts at risk ‘patient flow’ across the urgent care system.</td>
</tr>
</tbody>
</table>
Recommendations:

1) That the final report of the Care at Home Select Committee, and the recommendations therein, as set out at Appendix 1 to this report, be approved.

2) That a progress report in relation to all the recommendations contained within the final report be provided to the Health and Social Care Overview and Scrutiny Committee in six months’ time.
1. Executive summary

Full details of the executive summary are set out on page four of the Final Report of the Select Committee Review of Care at Home. (Appendix 1 to this report).

2. Background

Full details of the background to this report are set out on page six headed “The Process” of the Final Report of the Select Committee Review of Care at Home (Appendix 1 to this report).

3. Outcomes/outputs

The final report sets out the conclusions from the select committee review and the recommendations being made as a result of it. If the Health and Social Care Overview and Scrutiny Committee agree to the recommendations, the final recommendation is that a progress report in relation to all the recommendations be provided in six months’ time. The Council’s Constitution states that the decision maker shall respond to a final report of a select committee within one week of it being received from the Committee. Clearly due to the scope of the recommendations and involvement of a wide range of partners this is not realistic and the Committee would therefore expect an update report to fully understand the impact of its work. Following this, the Health and Social Care Overview and Scrutiny Committee can determine whether further monitoring is required.

4. Options available and consideration of risk

The options available to the committee are as follows –

**Option 1**
The Health and Social Care Overview and Scrutiny Committee approves the recommendations in the final report of the select committee review.

**Option 2**
The Health and Social Care Overview and Scrutiny Committee approves the recommendations in the final report of the select committee review subject to any amendments.

Doing nothing is not an option as the evidence received during the select committee process indicates that there are issues that need to be resolved.
5. Proposed Way Forward

Both options enable the work of the Committee to be taken forward and achieve the objectives of the select committee review. The final recommendation in the final report is for a progress report in relation to all the recommendations be provided in six months’ time so that its effect can be monitored. Following on from this, the Health and Social Care Overview and Scrutiny Committee will then determine whether further monitoring is required.

6. Implications

<table>
<thead>
<tr>
<th>Implications</th>
<th>Relevant to proposals Y/N</th>
<th>Details and proposed measures to address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal/Governance</td>
<td>Y</td>
<td>While there are no legal implications arising directly from this report the work of the Committee may lead to recommendations being agreed which may have legal implications for organisations and these will need to be reviewed by the relevant organisations on a case by case basis.</td>
</tr>
<tr>
<td>Financial</td>
<td>Y</td>
<td>The Health and Social Care Overview and Scrutiny Committee is unable to financially assess the impact of the recommendations due to limited knowledge and the number of variable factors. However, this is something that organisations can undertake and feed back to the Committee as part of the progress report. In terms of Cornwall Council any work arising from the recommendations will need to be funded from with the relevant service existing approved budget. Any expenditure that cannot be contained within existing budgets would have to be the subject of a report to Cabinet before any expenditure was incurred.</td>
</tr>
<tr>
<td>Risk</td>
<td>Y</td>
<td>The recommendations contained within the report can be accepted, amended or rejected by organisations. If they are accepted or amended then a rationale for such should be produced and included in the progress report. If they are rejected then the reasons must be explained to the Health and Social Care Overview and Scrutiny Committee. Risk would therefore need to be assessed on a case by case basis.</td>
</tr>
</tbody>
</table>
Cornwall Council

<table>
<thead>
<tr>
<th>Equality and Diversity</th>
<th>Y</th>
<th>All groups were considered as per the original scope. The principal of the review was that there was equity of improved outcomes and service provision.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding</td>
<td>Y</td>
<td>Vulnerable adults should be positively impacted by the recommendations if they are implemented.</td>
</tr>
<tr>
<td>Information Management</td>
<td>N</td>
<td>Nil.</td>
</tr>
<tr>
<td>Community Safety, Crime and Disorder</td>
<td></td>
<td>Nil.</td>
</tr>
<tr>
<td>Health, Safety and Wellbeing</td>
<td>Y</td>
<td>If the recommendations of the report are actioned the Committee feel that there would be a positive impact on the population of Cornwall.</td>
</tr>
<tr>
<td>Other Implications</td>
<td>N</td>
<td>Nil</td>
</tr>
</tbody>
</table>

**Supporting Information**

**Appendices:**

Appendix 1 - The Final Report of the Select Committee Review of Care at Home

**Background Papers:**

[under provisions of the Local Government Act 1972]

None.

**Approval and clearance of report**

**All reports:**

<table>
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<tr>
<th>Final report sign offs</th>
<th>This report has been cleared by OR not significant/not required</th>
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<tbody>
<tr>
<td>Legal (if significant/required)</td>
<td>Richard Williams</td>
<td>23/03/16</td>
</tr>
<tr>
<td>Finance Required for all reports</td>
<td>John Bloomer</td>
<td>24/03/2016</td>
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HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

SELECT COMMITTEE REVIEW OF CARE AT HOME

December 2015

Report, together with formal minutes, oral and written evidence
HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE
The Health and Social Care Scrutiny Committee is appointed by Cornwall Council. Its Terms of Reference are set out in the Scrutiny Procedure Rules within the Council’s Constitution:


Health and Social Care Scrutiny Committee Membership
Chairman - Cllr Mike Eathorne - Gibbons (Independent)
Vice Chairman - Cllr David Parsons (Liberal Democrat)
Cllr Neil Burden (Independent)
Cllr Lisa Gorman (Conservative)
Cllr Pat Harvey (Independent)
Cllr Sue James (Liberal Democrat)
Cllr Phil Martin (Independent)
Cllr Sue Nicholas (Conservative)
Cllr Rob Rotchell (Liberal Democrat)
Cllr Hanna Toms (Labour)

Care At Home Select Committee Membership
Cllr Mike Eathorne - Gibbons (Independent)
Cllr Phil Martin (Independent)
Cllr Sue Nicholas (Conservative)
Cllr David Parsons (Liberal Democrat)
Cllr Rob Rotchell (Liberal Democrat)
Cllr Hanna Toms (Labour)

Powers
The Committee is one of two Scrutiny Committees established by Cornwall Council, the powers of which are set out in the Scrutiny Procedure Rules within the Council's Constitution.

Scrutiny Staff
The scrutiny staff supporting the select committee review were Leanne Martin (Democratic and Governance Officer) and Vickie Hacking (Democratic and Governance Officer).

Contacts
All correspondence should be addressed to Democratic Services, County Hall, Truro, Cornwall, TR1 3AY. The telephone number for general enquiries is 01872 322140. The Committee's email address is scrutiny@cornwall.gov.uk
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<td>The Process</td>
<td>6</td>
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<td>List of printed written evidence</td>
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**Executive Summary**

Health and Social Care Scrutiny Committee – Select Committee Review of Care At Home December 2015
The scope of the select committee was to seek to answer two questions:-

- Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?
- Will this lessen the impact on community or hospital settings, and improve outcomes for care users?

For clarification, the spine provider is a service set up by Cormac in autumn 2015 and is named COR Care. This was established to cover a shortfall in the system. The timing of the panel, only one month into the operation of the spine provider, meant that it was difficult to establish if there would be an enhancement in provision over a sustained period.

Evidence from the witnesses did present that the provider landscape was wary of the creation of COR Care and the impact it would have. There was however, recognition of the need for a service to act as a safety net.

The increase in pricing rate had made a difference and it was evident from the providers that this had enabled them to maintain their contracts and activity. However, due to the financial situation of commissioners, increased pricing on a cyclical basis could not be guaranteed and the market would have to consider this in their forecast modelling. There was increasing demand and financial pressure on all aspects of social care. There has to be the consideration of a levy of a social care precept which would be needed across all areas.

It was demonstrated that there was frustration by providers regarding back office functions and the resolution of these would enhance the ongoing relationship.

The creation of the framework had not established the landscape it had intended. The use of personal budgets and mistrust following the abortive initial procurement process was detrimental to its development. It has to be addressed in future commissioning of Care at Home services and within the health and social care integration plans.

The panel was unable to directly establish if the work undertaken thus far would improve outcomes for those in receipt of care at home; or in itself relieve winter pressures. The stabilisation of the Care at Home market is integral to system resilience and there is a need to address the recruitment and retention of staff in this field urgently.

The evidence gathering, including the witness days for the Select Committee, was undertaken in November and December 2015. Subsequently there has been a change in governance within Cornwall Council. This resulted in the cessation of the Health and Social Care Scrutiny Committee which initiated the review. Therefore, this report shall be considered by the newly formed Health and Social Care Overview and Scrutiny Committee.
This Select Committee was undertaken prior to the decision of Cornwall Council to levy the Adult Care precept with Council Tax. This will begin in April 2016.

The Panel would like to take the opportunity to thank all witnesses for their attendance and evidence. Additionally thanks are expressed to all members of the public who attended the sessions.
The Process

At the time of the review the Health and Social Care Scrutiny Committee had a responsibility to scrutinise the delivery of health and social care in Cornwall. The committee received a request from the Portfolio Holder for Adult Care to scrutinise the area of Care at Home. This request highlighted areas of concern regarding the commissioning and provision of Care at Home services. It had been necessary for Cornwall Council to increase the payments to LOT 1 Providers on the Care Framework and there was a risk that packages of care could be ended. Additionally a spine provider, COR CareCOR Care, was created in order to provide care packages for those difficult to place. Following consideration of this context it was recommended that a select committee be undertaken.

The select committee intended to seek answers to two questions –

- Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?

- Will this lessen the impact on community or hospital settings, and improve outcomes for care users?

And the scoping questions were defined as follows –

- Will the changes underway in the care at home framework place us in a better position to cope with the demand of winter pressures?

- Have lessons been learnt in order to inform future commissioning plans?

It is important that the recommendations are fully considered and implemented by the relevant organisations in order for Care at Home services to be provided in a coordinated and cohesive manner.
Observations, Conclusions and Recommendations

The Committee has listed its recommendations and then its observations with brief explanatory text underneath of their rationale.

Recommendations

1. Patients and families should receive clear and accurate information in hospital settings about onward care options and this should be received in a timely manner. NHS Kernow and Cornwall Council should ensure this takes place.

2. An approach and offer to staff for training and appropriate career pathways, subsidised by all areas of the sector including the NHS should be developed quickly, and existing Care at Home staff should be involved in this.

3. Cornwall Council should immediately address concerns regarding invoicing and payment times.

4. Cornwall Council should ensure that the views of those in receipt of care and their families are included in any future procurement process for Care at Home.

5. There needs to be clear evidence of continuing engagement between all providers (including COR Care) and commissioners. With greater integration and co-commissioning of services likely in the future it is vital that the lessons learnt from the framework procurement and implementation are not lost.

6. A future report(s) be received to include –
   i. Consideration of the prescription regime for patients in receipt of onward care
   ii. Potential development of a trusted assessor
   iii. The impact on current providers by the development and implementation of COR Care
   iv. The impact of the rise in hourly rate, to include information from providers
   v. Specific information demonstrating the impact on winter pressures of both the increase in funding and the creation of the spine provider
   vi. Information regarding the discussion at the Employment and Skills Board referenced by Unison
   vii. If levied, the use of the Adult Care precept and how the spend is agreed.
**General Observations**

The panel was grateful for the time and evidence provided by all witnesses.

There were many areas brought up in the discussion, some of which fell beyond the terms of reference for the panel. All questions and answers have been included in the minutes of the evidence gathering days that are appended to this report.

Furthermore whilst many salient points were made by all witnesses it has been difficult for the panel to establish direct impacts in all areas of finding. This includes being unable to establish a direct correlation from the evidence provided to the direct market impact of the spine provider, COR Care.

The panel considered that the evidence provided by officers from the Commissioners on the evidence days was adequate; however it was not presented in a succinct or fluid manner. This was a cause of frustration.

**Thematic Observations and Conclusions**

**Impact on system resilience**

It was too early to see the impact on winter pressures of the changes of both the increase in funding and the creation of the spine provider. It was obvious that if these changes do not work then resilience in the system would lessen. The system has to have well developed and robust plans to reduce risk, of which COR Care will form part, but not all of the solution. The panel observed that there was no explanation of what would happen if a number of providers failed and what mitigation was in place.

The system operates at full capacity and the provision of care at home packages, along with other social care options, are a vital part of patient flow. It was apparent that this was recognised by all involved but that communication has to be improved. This includes the links between NHS providers and social care providers.

Patients and families should receive clear and accurate information in hospital settings about onward care options and this should be received in a timely manner. This might enable an increase in family caring or shorter stays.

The panel was interested to hear of the development of clinical pathways with onward care, such as that in orthopaedics described by Royal Cornwall Hospitals Trust. This is an area which might be able to be developed further.

Some suggestions within the evidence such as considering the prescription regime for patients in receipt of onward care, and that of a trusted assessor should be further explored.
From the evidence received the panel was not able to establish with absolute certainty that the framework system itself has impacted on delayed transfers of care. These delays could have happened using of a preferred supplier list. However, commissioning using the framework model had caused significant anger in the system and impacts on system resilience was somewhat inevitable.

**Patient Voice**
Concern was raised that the voice of the patient and their families was not being heard in the process. This concern was heightened that the report produced by Healthwatch Cornwall had not been as a result of patient concern but at the behest of providers. Access to patients was also predominantly facilitated by the providers, and the panel felt that this was not appropriate. Healthwatch Cornwall was created to be an independent advocate and in this circumstance this was questionable. In future there should be a patient led evidence base and this should be accepted by all parties and used to inform future decision making.

There should be consideration of patient views during the procurement processes. It is recognised that this may not be easy as it is predominately a financial negotiation, however with the increasing numbers of people opting for personalised budgets the views of those in receipt of care need to be heard.

**LOT 2 Providers**
There was disparity in negotiation with LOT2 providers. The Panel recognised that there was a difference in the manner of provision of care, especially around travel and transport of employees, and the insinuation LOT2 providers did not have to consider this as much as other providers. However, those cared for by LOT2 are very vulnerable and relationships with carers were likely to be steadfastly developed. Changes in carers would have a dramatic impact and with the development in LOT1 there could be impact on staffing for LOT2.

Following the evidence of Care at Home providers it was observed that there had been disparity between engagement with LOT1 and LOT 2 providers. Whilst recognising the aforementioned differences in the care that is provided it is advised that negotiations and discussions with LOT2 providers are advanced in order for there to be a recognised level of parity. There should be cognisance that any changes to LOT1 would have an impact on LOT2 and to Non Framework providers.

**Development of COR Care**
Whilst there was no direct evidence that there had been a demonstrative negative impact on current providers by the development of COR Care, the system is worried and this needs to be noted. The panel meetings did however take place shortly after its initiation.
There was recognition as to why the entity had been created but the anxiety that COR Care might go beyond its initial remit was palpable. It was observed that providers believed COR Care may lead to further destabilisation of the market and impact on recruitment and retention. When Commissioners look at future procurement of care at home services, and at any possible development of COR Care, this needs careful consideration and transparent explanation.

**Recruitment, Retention and Pay**
Throughout all of the evidence received, the one area that was overwhelming was that of employee recruitment and retention. This was linked to both pay and career aspirations. It cannot be overstated the impact this is having on all providers, whomever they are. All Care at Home providers, NHS providers and COR Care are recruiting from the same pool of potential employees. This was unsustainable and was a finite resource.

Private providers were often placed at a disadvantage due to the pay rates that were able to be offered by statutory providers and by those purchasing their own care. The Care at Home providers likened their ability to provide rates of pay akin to those offered by supermarkets as detrimental to recruitment. The decision to want to work in health and social care seemed to be driven by a societal value rather than financial and this should not be relied upon. It must also be considered the largely part time employment contracts required by employees in the sector.

Evidence from Unison explained that the Employment and Skills Board were looking into the training needs of staff and what could be implemented to ensure there is career progression within the sector. This discussion should be followed closely by those in the system and implemented where possible.

This is a national dilemma and Cornwall needs to look beyond its boundaries to help find solutions. There is no quick fix for this problem and there has to be a concerted effort from all to improve the offer for possible careers in the sector.

An approach and offer to staff for training and the development of career pathways, subsidised by all areas of the sector including the NHS would be beneficial. This could include training within settings such as community hospitals.

It is recognised that the Government has provided the ability for the authority to increase council tax with a precept for social care. This precept has to be considered to help bolster the care at home sector, however this is with recognition that although a major part of the system there are other draws on the social care budget that also needed to be addressed. If the decision is taken to apply the precept it will need to be identified where these additional monies would be spent. Identification of this spend separately from the general budget
would help in explaining to the providers and the public where the monies were directed and why.

**Unresolved mistrust**
The evidence given by some providers, and by commissioners, showed that there is still unresolved mistrust. Providers did not always appear to fully recognise the current financial constraints and pressures on local authorities and NHS commissioners and felt their own pressures were not recognised by them. There was a palpable level of hostility toward local authority officers and to some this was as a result of association to previous management structures.

The intervention by the Portfolio Holder for Adult Care appeared to be useful and welcome. However, it did not appear to have provided a forum for constructing effective partnership working but had certainly aided the airing of views. The picture painted by commissioners was that relations had improved and that all issues were being or had been addressed. This was at odds with other evidence received. Local authority witnesses appeared defensive and this would not help effective communication and discussion.

Commitment to improving relations was apparent from the commissioners but this felt linked to the concerns of the current volume and lack of resilience in the system and not to the ongoing issues being brought to the fore.

There has to be progression for all involved in relation to this. The system will not function effectively whilst it is operating in a hostile environment.

From the evidence of NHS providers it appeared that there were situations where families felt their relatives should remain in a hospital setting as they were unsure or had a lack of trust in social care options. This mistrust also requires addressing if progress is to be made. It is crucial for patients to trust the whole system to provide them with the best care.

**Integration, new models of care and care providers**
It was observed from witness evidence that there was a lack of forethought about how care at home services will be considered in the ongoing integration of health and social care. This lack of evidence caused significant concern for the select committee, and adds to the angst expressed by the providers. The lessons learnt so far should not be lost in the integration discussions and key links to providers and those on the ground such as between carers and district nurses need to be protected.

Currently there are differences in processes between the main commissioners. If services are to be commissioned from NHS Kernow this needs to be fully examined and planned although NHS Kernow implied they did not envisage a
change from traditional spot purchasing and Cornwall Council seemed intent on continuing with a framework system.

There is unlikely to be any new money coming into the system and if a Council Tax precept is enabled, it is likely to be spread across all adult social care requirements.

Providers may need to acknowledge they might have to change their business models as changes take place in the future, especially if additional funding is not available. It needs to be considered that a reduction in providers might be needed in order to enhance the profitable economies of scale.

**Back office support**

Providers had a number of concerns regarding back office support for the framework within the local authority.

Frustrations were evident regarding the speed of payment, processing of invoices and specified points of contact. In the short term this could begin to be alleviated by addressing concerns about invoicing and payment times.

Additional evidence received from Cornwall Council financial services provided information about how this is beginning to occur and this was welcomed but needs to continue. There has to be constructive and ongoing dialogue with providers about how that is progressed.

A single point of contact within Education, Health and Social Care for providers might be useful, but the limitations of this role would also have to be recognised.

Longer term there will need to be plans to address issues on both sides, with an agreed understanding of support and processes.

Considering the larger anxieties these areas should be addressed as a priority.

**Ethical care charter**

It was disappointing that the only organisation who had been able to sign the Ethical Care Charter was COR Care. It was felt that this was only possible due to the unique way they were set up and operated.

The panel reflected that the Charter is an aspiration for many providers, however, it would be difficult to achieve with the current contracting arrangements.

If care providers were able to sign the Charter it might provide an incentive for people considering working in the care sector.
**Facilitating re-procurement and commissioning**

The current price increase was shown to be helping in the interim but from the evidence received the sustainability of the services was still in jeopardy. It appears that whilst the framework model was implemented with the best of intention, there was always an underlying tension over it being a cost based system. This is difficult to avoid in times of current financial constraints. The subsequent pressure on the framework means it has been unable to cope with the demands upon it. Framework providers could not meet the demand and the Council could not enforce the contractual framework.

This was compounded by the impact of direct payments. The Council had a government set target to increase the volume of people in receipt of direct payment and this inevitably was at odds with the framework resulting in a change in volume on which the financial modelling was based. There have been a number of other national changes such as new legislation which have altered the landscape since the framework was introduced.

A perceived lack of transparency in the modelling of the framework remains an issue and this has to be addressed in future commissioning planning. There has to be clear and open modelling and pricing; national bodies, such as United Kingdom Homecare Association (UKHCA), should be consulted as part of this. Comparison to any available good practice in this area of commissioning should be included.

Likewise there should be identification of the rates provided elsewhere in the south west and possibly other comparable local authority areas. Concerns, complaints and feedback from providers who are part of the framework, and those who were not successful have to be addressed in the future commissioning of Care at Home services and within the health and social care integration programme.

There are large national providers of services who do not appear to want to operate in Cornwall. It would be useful to discuss with them why this is the case, and how that information could help develop future plans. There needs to be a commitment for robust due diligence with sufficient financial and legal support for any new procurement process. Preventing the issues that occurred in the first procurement is paramount.

LOT 2 providers gave evidence regarding to a previous procurement with regards to learning disabilities which seemed highly regarded by the market. This should be examined to see what could be taken from this process in order to inform any future procurement. Providers should be able to provide examples of what they considered good practise.
## Terms of Reference of the Review

<table>
<thead>
<tr>
<th>Subject Name</th>
<th>Care at Home Select Committee</th>
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</thead>
</table>
| **Purpose, Question and Key Objectives** | Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?  
Will this lessen the impact on community or hospital settings, and improve outcomes for care users? |
| **Scope of the work** | Will the changes underway in the care at home framework place us in a better position to cope with the demand of winter pressures?  
Have lessons been learnt in order to inform future commissioning plans |
| **Not included in the scope** | Care and Nursing Home Placements and packages  
Support funded by other organisations |
| **Nature of Review (Select Committee or Inquiry Day)** | Select Committee process over 1 or 2 days |
| **Status of paperwork, i.e., is it ‘exempt, not for publication’ or can it be made public on request?** | Public unless subject to Access to Information Procedure Rules.  
**Note:** It may be necessary to add an item to each agenda regarding the status of paperwork relating to that meeting |
| **Divisions affected** | All |
| **Division Members** | All |
| **Resource requirements** | **Staff time (days)** | **Budget (£)** |
| | TBC | From within existing budgets |
| **Additional Resource Implications** | X Financial  
X Legal  
☐ Equality and Diversity  
☐ Personnel/Trade Unions |
| **Impact on vulnerable Groups** | Is the work to be carried out by the group likely to have a positive or negative impact on any groups in the community? Consider the following groups:  
- People with disabilities  
- The elderly or young people  
- Men or women (gender specific)  
- Gay men or lesbians  
- Religion, belief or faith, or no faith  
- Race  
- Gender reassignment  
- Marriage and civil partnership  
- Pregnancy and maternity  

If there is any impact, you should consider involving someone from the group(s)** |
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<td><strong>Background</strong></td>
<td>Select Committee requested by Cllr Jim McKenna.</td>
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Formal Minutes

CORNWALL COUNCIL

HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

MINUTES of a Meeting of the Health and Social Care Scrutiny Committee held in the Trelawny Room, Cornwall Council, County Hall, Truro TR1 3AY on Friday 27 November 2015 commencing at Time Not Specified.

Present: - Councillors: Eathorne-Gibbons (Chairman)
          Parsons (Vice-Chairman)

          P Martin, Rotchell and H Toms.

Apologies for absence: - Councillors: Burden, Gorman, Harvey, James and Nicholas.

DECLARATIONS OF INTEREST
(Agenda No. 1)

There were no declarations of interest.

SCRUTINY REVIEW OF CARE AT HOME
(Agenda No. 2)

HSC/14

10.00 - PORTFOLIO HOLDER FOR ADULT CARE
(Agenda No. 3)

By way of introduction, could you provide us with your name and details of your connection with the Care at home sector.

My name is Councillor Jim Mckenna and I am the Portfolio Holder with responsibility for Adult Social Care.

Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector Care at Home provision?

The steps currently being taken were sufficient to support and stabilise the market. Prior to action being taken, Lot One Providers had indicated that they would withdraw from the Framework, however they were now working with the Council and have not withdrawn from providing care provision.

There is further work is required and there is a meeting planned with the Lot Two Providers to address the concerns they have raised in relation to the Framework.
How do you think the system would cope with winter pressures?

There is still an issue with patient flow. There is an increasing number of people presenting at the Royal Cornwall Hospital Trust and leaving the hospital without a suitable care package in place. If the levels of demand are as predicted then the system should be able to cope, however the system is not robust enough to address all of the issues.

The respective parties are now all working together in a more collaborative way, which is positive, and we are working on addressing the number of instances where RCHT is on black alert. Putting in place the relevant Care at Home packages will be one of the contributing factors to reducing the number of black alerts.

What has been the impact on care users, how do we know that outcomes will improve for care users and how is the voice of the person in receipt of care (and their families) heard?

Six to Nine Months ago, I received a lot of contact from Members and families in relation to issues being experienced with Care at Home packages. In response, I set up a Carers Forum that is designed to tease out the issues experienced by both sides and I am working closely with Health Watch as they represent the patience’s voice, to gain an understanding of the issues. There has also been an appointment made to the Head of Service (Adult Care and Support) role and these two factors combined have resulted in fewer direct complaints received.

What is the biggest lesson that has been learnt from this process and/or what would be done differently if a similar process were to be undertaken in the future?

Lessons have been learnt, the Framework and Contract were awarded prior to me taking up my role as Portfolio Holder. As part of the contract award there were assumptions made in relation to the hourly rate of pay to be paid to Providers and due to the issues faced following the awarding of the Framework there is now a greater understanding of what is required prior to any contracts being awarded. Two of the main learning points were that you have to work with the Providers prior to the contract specification being devised to gain an understanding of the market and sufficient resource needs to be assigned to the process. There also needs to be an understanding that the procurement of care provision is not a short-term way to achieve budget savings.

In respect of Care at Home services, what will lessen the impact on community or hospital settings, and improve outcomes for care users?

There needs to be sufficient staff available to fulfil the care package requirements and this is not the current situation. However, the Council has taken steps to enhance resource with the formation of the Spine Provider and this provision has been for a month.

To maintain and enhance capacity the staff currently working in the sector need to remain motivated and two steps Council has taken to support this includes
only commissioning visits that are a minimum of 30 minutes in length visits and it has implemented the living wage. There are also plans in place to provide career pathways and opportunities for carers.

**Have you any evidence to demonstrate that staff morale has improved?**

The development of the career pathways will take time. Cornwall Care staff are earning more money so the morale amongst the staff is improving and there is some evidence that staff retention is improving. The recruitment and retention of staff over future months will provide evidence of the level of morale within the workforce.

**Do you see that the implementation of the living wage will present difficulties to the providers?**

There is recognition by the Council that they need to address the issues that are being experienced in relation to the Care at Home contract and the Council will continue to work with Providers to ensure care can be delivered. There has been a recent Government announcement in relation to Councils’ being able to levy a 2% precept for adult social care provision and the Council could decide to introduce the precept and this will provide additional money to assist in meeting the growing demand for Care at Home provision.

**How will the Council fund any overspend in this area, how will it impact on other services and what has the impact been of the additional £4.5m?**

The current demand is outstripping the capacity in service provision. The ideal situation would be to receive additional grant funding. All opportunities need to be sought regarding delivering the care provision in the most efficient way. The current way care is provided to support people with learning disabilities and physical disabilities needs reviewing to ensure it is being delivered in the most efficient way. Additional funding is required to ensure that Care at Home provision can be provided at an acceptable standard.

The issue is wider than the care sector and opportunities need to be sought in other areas, for example when housing developments are proposed consideration should be given to providing supported housing within the development, which would allow people to live independently in the community for as long as possible.

**There are several pressures on the Adult Care Budget, how assured are you that the budget is adequate?**

I have concerns regarding the saving target that has been set for the next two years and the impact of failing to achieve the savings could have on other services. There has been a target of £12 million for 2016/17, which is dependent on the integration proposals and there are ongoing discussions with regard to what savings can be achieved. There is concern that if the integration does not achieve the forecast savings there will be a huge shortfall in the budget and this will impact on other service budgets.
There has been a change in leadership and key posts have been recruited to, therefore I have more reassurance that the budget will be managed appropriately.

*Is there confidence that future issues will be resolved?*

The working relationship between providers and the Council have improved, in the past there was reluctance amongst Council officers to work with the providers, however the culture is changing and partners are recognising the benefits of working together.

£20 million pounds could be put into service but this would not solve all the issues and there would still be gaps, there needs to be changes in the way we work. If I feel that there is a need for extra funding, I will put the case forward and ask for it and this was evidenced by the recent request that received support from the Policy Advisory Committee and Cabinet to use of £5 million from reserves to support the service.

*You raised a point earlier in relation to shelter housing and assisted living accommodation, is this going back what happened in the past?*

Currently there is an absence of this type of accommodation within the community including the absence of suitable housing for people with learning and physical disabilities. Care packages can be provided for these individuals, however if the property they are living in is unsuitable then they will not be able to continue living independently and will have no other option than to move into provision such as a care home.

*How do you envisage suitable housing being provided in the community?*

Local Members need to work with and lobby the Planning Service, for example, there is currently a development proposed on the former St Clare site in Penzance and I have been working with the Planning Service to negotiate the provision of supportive living accommodation on the proposed application site.

*Is there anything that you would like to add by way of summary?*

I have a question for the Committee, that I request you put to Senior Officers as part of this process, ‘When the tender process was undertaken for the Lot One and Lot Two Providers, why was the hourly rate in the contracts agreed at that level and why were no concerns raised regarding impact from the reduction in the rate?’

**10.35 - LOT 1 PROVIDER REPRESENTATIVES**  
(Area No. 4)

*By way of introduction could you provide us with your name and details of your connection with Care at Home provision?*

I am Ian Williams the Project Director for Cornwall Care and I am Kevin Taylor McKale from Taylors of Grampound. Following a vote taken by Lot One
Providers, we have been chosen to attend the Select Committee to represent their views.

**Will the steps being taken in terms of pricing and a Spine Provider be sufficient to support and enhance private sector care at home provision?**

There is a consensus among the providers that the steps being taken will not address the issues. The ideas are good in principle but the care sector works with incredible low margins and the reduced rate of paid has had an impact on the ability of providers to recruit and retain staff. The hourly rate does not allow us to provide an attractive rate to pay to attract individuals to join the sector and we are working in a highly competitive jobs market where the large retailers can offer a higher rate of pay for roles that carry less responsibility than those in the care sector.

The introduction of the Spine Provider is good in principle as it allows the Council to commission care provision when other Providers do not have the capacity to provide a package. However, from the Provider’s perception the Spine Provider will be able to offer higher rates of pay to its employees. Which in turn will have a negative impact on other providers who cannot offer the same rates of pay and could result in their staff leaving to work with the Spine Provider, further reducing the capacity of Providers in the market and this could lead to the Spine Provider being required to take on more care packages. Providers have expressed concern that over time the Spine Provider will become the main care provider in Cornwall.

**You bid at a rate that you had established, what has subsequently changed in order for the system to not work effectively?**

The providers submitted a bid based upon the paperwork supplied as part of the tender documentation and the information supplied at the pre-tender meetings and this rate was £14.50.

Within the documentation, there were details in relation to volume of cases that the Framework Providers would be working with and it was reported that this information was based upon the 2012 market.

The Providers based their hourly rates in the tender bids on this volume information and believed that they would be entering into a partnership with Cornwall Council. In reality, there was no working relationship with the Council and the volume of care packages was not as outlined at the tender stage due to the approach that the Council took regarding direct payments. The Council promoted the option for care to be purchased directly rather than opting to go through the Council’s Framework. This approach has led to Non-Framework Providers receiving £16 per hour and left the Framework Providers in an impossible position receiving a lower rate. In addition there has been an increase in the minimum wage, it has become more difficult to recruit and retain staff, the Care Quality Commission requirements are increasing, there are additional administration costs that are associated with being a member of the Framework such as meeting data protection legislation and collecting the data required to meet the Key Performance Indicators. All these factors have had an impact on the Care sector, however being tied into the Framework has had an unforeseen
impact on the Framework Providers, and the Council has taken far too long to respond to the issues raised by the Providers.

In the tendering process, details were requested regarding the financial modelling that the Council had undertaken to arrive at the £14.50 per hour rate. However, details of the modelling were not provided and were not seen by the Providers until the current Portfolio Holder became involved in the situation.

*How do you think the system will cope with winter pressures?*

Until the providers can recruit and retain enough staff within their organisations there is not going to be the required capacity to prevent gridlock within the system. The uplift in the hourly rate provided by the Council to Framework Providers has assisted in establishing the situation but staff recruitment and retention remains an issue.

*What impact will the requirement to pay the living wage have on Providers?*

If Framework Providers receive additional funding from the Council then there will be no issues in implementing the living wage, however if there is no uplift provided this will place a further burden on providers and they will struggle to meet their obligations.

*What is the level of staff retention and recruitment, and what is being done regarding workforce?*

We can all work together and brain storm incentives and initiatives to recruit staff, however the issue is not related to the lack of innovation. It is about getting the required traction, working through the issues, and seeing them through to the end. There needs to be a plan put in place and some tangible outcomes achieved to put in place genuine career opportunities. The human cost of not being able to recruit and retain staff is colossal and affects those who need care, their families, and the carers.

*Currently it is believed that relatives deliver 80% of Care at Home, if this reduces what would the impact be?*

Cornwall has a higher proportion of elderly people than other areas of the country and the increasing number of people requiring care puts additional pressure on the community. The situation is further exasperated by the introduction of direct payments in that this gives individuals and families the right to choose their carer and could impact on the quality of care delivered and the number of packages available for the Framework Providers.

*How do you see the sustainability and modernisation of care at home services?*

If you are serious about addressing the issues, a full-scale regime of change is required and this may be achieved through devolution. However, the Providers need to provide, the Commissioners need to commission and the Regulators need to regulate.
The Providers currently feel that the officers commissioning the services do not have an understanding of the market. There needs to be a closer working relationship fostered and issues have to be addressed.

**What do you want the Council to do?**

The Council needs to engage with Providers at every stage as there is currently the feeling that decisions are being made without the views of Providers being taken into account and the Council needs to address this issue. In addition, there is a fundamental problem with the Council’s payment system and this is also impacting on the Providers.

**What is the biggest lesson you have learnt from the process?**

The biggest lesson learnt is that there needs to be clearer engagement between all the parties and information needs to be shared. The Council held a number of meetings with Providers who were considering tendering. At these meetings the Council presented details to suggest that following the implementation of the Framework, only the Providers who successful tendered would be offered new work through the Council. The Council also expressed a wish to work with a limited number of Providers and the notion of subcontracting by successful Providers to non-successful Providers would be positively encouraged on the basis of this information many Providers made the decision to submit their tenders.

However, this has not been the case and has caused mistrust between the Providers and the Council, and it has taken a long time for the Council to respond and take steps to resolve the issues. Time needs to be time taken to ensure that all the issues are resolved and all parties need to have a true dialog and actively work together.

**What are the experiences of the discharge process in relation to Care at Home packages?**

There is a lack of timely communication between all parties. This has a direct impact on the discharge process as this reduces the time available to commission a suitable care package.

There is also an issue with the purchase order system, the purchase orders are not being issued in a timely and accurate way, which is causing a lot of additional work and they are not receiving a timely and correct payment. This means that resource is diverted from providing the care packages.

**How can communication between the parties be improved?**

The CPIC Members have tried to move forward by introducing a care passport that will provide better information about an individual and will be available to the relevant parties.

The communication issues experienced are mainly related to the processes that are in place and there is not sufficient resource in place to implement procedural
changes. The issue could be mitigated with the introduction of joint commissioning arrangements.

Is there anything you would like to add by way of summary?

In the short term the Council needs to make a decision regarding the uncoupling the CMT200 system from the system used for paying carers. The current system is very resource intensive and means time is detracted from providing care. There is a genuine feeling among Providers that they have been used to pilot the system and where mislead about the capability and ease of use of the software. By uncoupling the system, it would allow more time to focus on the recruitment and retention of staff.

In the longer term there needs to be a regime and culture change where the ethos is centred on working together.

11.20 - LOT 2 PROVIDER REPRESENTATIVES
(Agency No. 5)

By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?

I am Lyn Toman, the Area director for the Brandon Trust, and I am Tim Jones from United Response, and we are representing the views of the Lot 2 Providers.

Can you outline the difference between the Lot 1 and Lot 2 Providers?

We provide high levels of support for people with very complex needs. A lot of the support is provided in an individual’s home on a ratio of 2-1 or 1-1 and can be in place for substantial periods of a person’s life.

The support provided is more intensive than Lot 1 packages and the aim is to try to allow people to stay within their communities for as long as possible. However, this is not always possible due to the lack of suitable housing available in the county. Lot Two Providers supply support that is more intensive over a longer period for a smaller number of people.

Will the steps being taken in terms of pricing and the introduction of the Spine Provider be sufficient to support and enhance Care at Home provision?

It is difficult for us to comment, as we have not yet moved onto the higher hourly rate and in terms of the overall strategy, we have not had the opportunity to provide any input.

The Spine Provider does not provide the same packages of care as the Lot Two Providers, therefore there is minimal impact, however concern has been raised regarding the recruitment and retention of staff. Based upon the current hourly rate paid by the Council of £13.49 an hour we are unable to attract staff to work for the Providers. The national minimum wage is set at £7.20, however to recruit and retain the staff we pay a rate at £7.82 the difference is currently being funded through company reserves and this position cannot be sustained.
What is the difference since the introduction of the Framework?

Lot 1 Care providers travel from the respective homes of people they care for, and can see several individuals in a day, therefore they are transient in nature, which makes the packages more expensive.

When we entered into the Framework, it was based on the assumption that there would be a lot of growth as there would be fewer Providers able to apply for the packages.

The first tender process impacted on the subsequent tender process because the second process became more competitive and was based on the benchmarking from the first tender process.

Could you elaborate further on the comment you made in relation to the assumptions made about growth?

Prior to the Framework being introduced the Council commissioned care packages from several Providers and the Council indicated that when the Framework was implemented care packages would be commissioned through the Framework Providers. The number of Providers would be reduced in number, therefore the assumption was made that there would be a growth in the number of packages available for the Framework Providers.

In reality this was not the case due to the introduction and promotion of direct payments, which enables families to commission the care required directly, therefore they can opt to have their care package provided by Non-Framework Providers, meaning forecast growth in the number of packages available for the Framework Providers did not materialise.

What did you believe would happen after the contract had been awarded and what has been done to date to address any issues that arose?

There is a meeting scheduled to discuss the issues being raised by the Lot 2 Framework Providers and it is hoped that this will be the start of issues being addressed.

The issues that are being experienced relate to direct payments, although we fully support the principal of direct payments because this gives the individual some autonomy over their care and negates the requirement for their care Provider to tender every three years. The Lot 2 Providers are requesting more equality, the other issue for the Council to resolve relates to the payment of the direct payments to the individuals as some of them have been waiting over 12 months for payment to receive their payment.

Other issues relate to the mobilisation of the top five Framework Providers and the recruitment and retention of staff.

In the evidence presented by the Lot 1 Providers, they advised that they have collated evidence to support their request for an increase in the hourly rate paid by the Council. Do you have the same evidence to support your case?
Yes. The UK Care at Home modelling is slightly different for the Lot 2 Providers, however we are in the process of compiling the relevant information, and these details combined with the details from the CCG will support our case.

Concern has been expressed that the issues raised regarding the Lot 2 Providers will be overshadowed by the devolution and integration agenda and there is a debate as to whether Lot 2 Providers sit in the health function or was the responsibility of the Council.

**How do you see the sustainability and modernisation of Care at Home services?**

There is support required to stabilise the services and this is centred on the hourly rate paid by the Council because the current position is not sustainable and it is reaching a critical point. There is not equity between the rates paid to the Lot 1 and Lot 2 Providers and there is an issue regarding the equity between the Framework and Non-Framework Providers.

To resolve some of the issues better communication is required between all parties and there needs to be improvements in the ways all parties work together. In 2006, the tender process for care provision involved the families of people who required care, this has not been the case for the last two tenders, and there is a perception that paper and bureaucracy drove these tenders.

There is an acknowledgement that there are budget pressures and a national debate is required about care and support provision, but there are issues that can be resolved at a local level.

**What is the current turnover rate for staff?**

Up until the implementation of the Framework the turnover of staff was low, however now turnover has increased to approximately 30%. Staff that have worked for the organisation for a long time are now feeling undervalued, demoralised and are deciding to leave their roles and the rate of pay has a major impact on the recruitment and retention of staff.

**What is the biggest lesson that has been learnt from the process and/or what would you do differently if you were going through a similar process in the future?**

In hindsight, it would be better to fail to be accepted on the Framework.

Next time the Council enters into a tendering process of this nature they should look back at the process that was undertaken in 2006. This was a good experience, and involving parents and carers fostered effective partnership working.

The Lot 1 and Lot 2 procurement packages should to be treated and dealt with separately as they are different types of provision.

The procurement process was difficult to navigate through and following the failure of the first procurement, all parties were more sensitive on the second round of procurement. In addition, the recent restructure at the Council has...
caused confusion and complication for the Providers and people receiving care as there were new people to communicate with and this further impacted the culture and processes issues experienced.

As Providers, we want solutions and we would like some input into how the issues are resolved. An increase in the hourly rate paid by the Council would be a start.

12.05 - CORNWALL PARTNERS IN CARE
(Agenda No. 6)

By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?

I am David Smith and I am Christine Rowbray, we are here to represent Cornwall Partners in Care, which is the trade association for the sector.

Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector Care at Home provision?

The initial guide price set out in the tender was too low and there is a sector wide issue regarding the recruitment and retention of staff, which is leading to capacity issues. The recent uplift in the hourly rate paid by the Council has helped stabilise the sector, as it has prevented Providers from going out of business, but there are wider issues that need to be addressed over the longer term.

The CPIC can understand the reason for the Council opting to set up the Spine Provider Provision however, it will be competing for the same staff and there are concerns that the Spine Provider will want to enter the direct payments market.

There is an issue with direct payments as they are currently paid at an hourly rate of £14.50 and this is not increased until the Council has reviewed the Providers and the process is currently taking up to a year.

How do you think the system will cope with winter pressures?

Cornwall Partners in Care have been engaging with the Council and NHS Kernow to look at ways of improving the process issues that are being experienced. There are various things that will improve the system, such as a retainer payment being made to Providers so that care packages can be maintained and do not need to be re-brokered following an individual’s stay in hospital. Providers could also assess their own packages rather than waiting for Council staff to undertake a full review, which would allow capacity to be released into the system, and in turn, would ease winter pressures. When a patient is in a position to be discharged from hospital, sometimes there is an issue with the information supplied by the hospital, which then impacts on the care package. By having a trusted assessor to evaluate the information and co-ordinate the equipment and support required, this could assist with the transition from hospital.

One of the other issues slowing the system down, although not directly related to the support package, relates to the prescribed medication. If the doctor
prescribes medication is to be taken three or four times a day, a more intensive care package is required, however if some regard is given to prescribing medication, the care package and the burden on the care providers can be reduced, freeing up more capacity in the system.

Better communication and co-ordination between all the organisations and the proposed integration of Health and Council services may help alleviate this issue.

**What should the hourly rate paid to providers be and what evidence do you have to substantiate this rate? How does the hourly rate impact on the recruitment of staff?**

The rate should be set at the UKHCA recommended rates. The sector is competing with other organisations such as retail and tourism. People who work within the care sector are paid the minimum wage, take on a lot of responsibility and work in a sector that has received a bad press. It is imperative that employers within the care sector offer a package of measures to make the role more attractive and this will assist with the recruitment and retention of staff.

Recently some providers have increased the starting hourly rate to attract people into the sector, this has been implemented for approximately four weeks, and there has been an increase in the number of applications received for advertised roles.

However to retain staff the profile of the care sector needs to be improved and there needs to be career pathways developed.

**How do you see the sustainability and the modernisation of Care at Home services?**

Since the introduction of the Framework agreement, the sector has taken a backward step. There was not enough input from the Providers in the sector at the pre-tender stage and the first procurement process created a lot of fragmentation within the sector.

Providers had requested details of the evidence that the Council had based their tender criteria on but the Council had not been forthcoming in providing the information.

Moving forward the Commissioners of Care at Home provision need to have more understanding of the pressures faced by Providers and there needs to be meaningful dialogue and true engagement between all partners.

**What is the biggest lesson that you have learnt from the process and what would you do differently if you were to go through a similar process in the future?**

In hindsight, we would not enter into the tender process, it was a costly process and unsettled staff and individuals. If we were to do it in the future the communication would need to be improved and there would need to be a greater openness.

**Is there anything that you would like to add by way of summary?**
There is a concern in the sector that the issues the providers have experienced with the Council, will be replicated again following the integration as there is not the confidence that lessons have been learnt.

**13.30 - NON FRAMEWORK PROVIDER REPRESENTATIVES**  
(Agenda No. 7)

*By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?*

I am Trish Berryman and I am Mary Anson, we are representing the Non-Framework Providers.

*Will the steps being taken in terms of pricing and the introduction of the Spine Provider provision be sufficient to support and enhance private sector Care at Home provision?*

The increase in the national minimum wage will have an impact on the care sector as providers work to very tight margins and the increase in the hourly rate paid by the Council will not mitigate this.

There is currently some uncertainty about the rate that the Spine Provider will charge to deliver care packages and if they will be competing for care packages with the existing Providers.

One of the issues regarding being paid an hourly rate is that visits are generally ½ an hour long, in most cases, and the remainder of the time is taken up with travel, therefore the carer is not available for the full hour. In addition the employer has to pay national insurance, holiday pay, insurance, training costs and for staff uniforms. The hourly rate paid is not sufficient to cover all the costs.

The Spine Provider will not address these issues and is a sticking plaster. The rate increase to £16.00 per hour introduced in September is going to take time to filter through, as providers are only eligible for the higher rate following an assessment, which is taking the Council some time to complete. Once the assessment has been carried out the Providers are not always informed which leads to a delay in amending the billing to take into account the increase.

*Following the implementation of the Framework, what has changed in order for the system to not work effectively?*

Clients received an ultimatum in respect of their care provision, they could opt to receive a direct payment to commission their own care, or they could stay with the Council’s Framework Provider. Those that choose the Framework providers packages were moved from the Non-Framework Providers to those that were part of the Framework at very short notice. In a period of six to nine months the Non-Framework Providers business dropped by 50%. There was very little time to put mitigation in place, this unsettled the staff, and as a result, several of them left.
Can you expand on your comments regarding the tender process?

There were effectively two tender processes the first one that failed and the second process that resulted in the current situation. The Framework has been very damaging for the sector in terms of loss of money, staff, and growth in the industry.

The Council should revert to the preferred suppliers list to enable spot purchasing, as there is a finite amount of resource in Cornwall and unlike other areas of the Country, Cornwall does not have agencies to pick up the packages that cannot be delivered by the providers.

What is the level of staff retention and recruitment, and what is being done regarding the workforce?

There are a variety of issues that impact on staff recruitment and retention, the number of staff who can only work a maximum of 16 hours a week due to claiming tax credits therefore they are not available to work additional hours to cover any shortfall in resource. The shortage of affordable housing within the county has an impact on the locations where carers can afford to live. The current workforce is made up of mainly women who have children or are mature therefore there needs to be a focus on making the care sector more appealing to younger people. We are currently looking at ways to put in place a career pathway. In addition, there needs to be a more positive depiction of the sector within the media.

The recent removal of the bursary provided for nursing qualifications will have an impact on the care sector as it removal one of the potential career pathways and many apprentices are not work ready and find the transition into this type of work environment difficulty.

How do you think the system will cope with winter pressures?

Unless additional staff can be recruited and retained there will always be an issue regarding capacity.

Currently the housing stock is restricting people moving back into the community after a stay in hospital, as there are not enough suitable properties for individuals with care needs.

Care staff are choosing to leave the Providers to go and work at the hospital, agencies or in other sectors and it is increasingly hard to fill the vacancies that they leave behind.

What steps are providers taking to retain their staff?

Providers have been trying a range of measures to promote staff retention, these include providing lease cars and affordable housing to reduce the cost to employees.

Would you tender to be included within the Framework?
As it currently stands, we would not enter a tender process and commit to the Framework as we would like to see the outcome of the proposed integration programme.

**How do you believe the tender process could be improved?**

The Council needs to include the Providers in the tendering process and when developing the draft Framework, the whole sector needs bringing together. In the last tender, there were providers who opted not to bid due to the recommended hourly rate and there being floors within the rationale behind the figure. It is the view of the Non-Framework Providers that care should be commissioned through a spot purchasing process and the Framework should be abolished.

*Is there anything that you would like to add by way of summary?*

There is a wider issue when it comes to recruitment relating to management roles in the care sector. There are currently junior staff or more mature staff working in the sector that are not wanting to take on the responsibility of managing a care home due to the regulations regarding personal culpability, and the amount of bureaucracy required to fulfil the requirements put in place for Adult Social Care.

15:00 - **HEALTHWATCH CORNWALL**  
(Agenda No. 9)

*By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?*

My name is Debbie Pritchard and I am the Chief Executive for Healthwatch.

*Describe the methodology and learning from the work that you have undertaken?*

In undertaking its work, Healthwatch based 40% of its findings on feedback received from the Freephone line, information submitted through the website, emails and details received from partner organisations. The other 60% of the information was gained by seeking active feedback through our outreach work. This involved collating anonymously details of real life experiences, details of single examples raised and collating information regarding the small issues. Through this work, it was deemed that the level of concern expressed warranted a formal project.

There was concern raised about Care at Home issues in Autumn 2014 and following these concerns being raised by the organisation, Healthwatch meet with NHS Kernow and the Cornwall Council Commissioners to advise them of the findings.

Healthwatch undertook further investigations and arranged and attended a variety of meetings, forums, and sessions with the Providers where they were asked a series of specific questions. In addition there was a survey circulated to clients to enable a picture to be developed. There was a meeting held with the
Portfolio Holder for Adult Social Care and Healthwatch approached the media to request a public response regarding Care at Home provision. As a result, a report was drafted and sent to the Commissioners in the first instance to allow them to address the issues and promote action.

In May 2015, a final report was produced and the report acknowledges that the Council had undertaken various actions to start rectifying the issues.

*How do you validate the information that you receive?*

There was feedback gathered from over 70 people and there is no validation of the information gained as it is treated in an open and candid way. We also gather information from all parties involved to obtain a rounded perspective.

*What were the learnings from the work undertaken?*

There were several areas of concern that were raised as part of the project which included lack of capacity within the sector to provide the required care packages with some evidence of packages being handed back to the Commissioners and serious concerns regarding the pay and conditions of the staff delivering the care resulting in staff leaving the sector. There was also an issue with the two-way communication between the Providers and Cornwall Council.

The Framework Providers had not been given the required information regarding care situations, the Non-Framework providers secured contracts with the NHS and post the implementation of the Framework the Council continued to use Non-Framework Providers to carry out care packages. Providers were experiencing cash flow problems due to invoicing issues, direct payments, and service user contributions.

Healthwatch noted that there was still a good level of care being provided but concern was raised regarding the training provided for younger carers. The findings were reported to the Portfolio Holder for Adult Social Care and he acted quickly to improve the situation.

*Are there any plans to follow up the work undertaken?*

There are no current plans in the immediate future to follow up the work as Healthwatch are happy with the core care set up, a lot of progress has been made through the Framework Group and there has been an improvement in response to the issues raised.

*Have Healthwatch nationally looked at the matter?*

The purpose of Healthwatch is to respond to issues that arise locally and the issue raised in relation to Care at Home provision has not formally been escalated to the national level, however we have shared the report nationally. There has not been the same sort of issues experienced nationally.

*Is there a vehicle to share the lessons learn for the work?*
There is an online Healthwatch Forum where work can be shared and it can act as a source of information.

*How is the voice of the person in receipt of care (and their families) heard?*

In the course of this piece of work, we found it quite difficult to hear the voice of the people in receipt of care and their families. Where the families had been badly affected, they would present their views, however it was more difficult to reach others receiving care packages. We are not sure if the reason for not sharing the information related to data protection issues, however, the issue may have been improved if there had been a closer working relationship with the Council.

The meeting ended at 15.20pm.

[The agenda and reports relating to the items referred to above are attached to the signed copy of the Minutes].
CORNWALL COUNCIL

HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

MINUTES of a Meeting of the Health and Social Care Scrutiny Committee held in the Trelawny Room, Cornwall Council, County Hall, Truro TR1 3AY on Friday 4 December 2015 commencing at 9.15 am.

Present:–  Councillors: Eathorne-Gibbons (Chairman)

Also in attendance:–  Councillors: Margaret Abban, Nicholas, Rotchell and H Toms.

Apologies for absence:–  Councillors: Burden, Gorman, Harvey, James, P Martin and Parsons.

DECLARATIONS OF INTEREST
(Agenda No. 1)

HSC/21  There were no declarations of interest.

SCRUTINY REVIEW OF CARE AT HOME
(Agenda No. 2)

HSC/22

09.15 - UNISON REPRESENTATIVE
(Agenda No. 3)

HSC/23  By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

I am Stuart Roden and I am here to represent the Employee representatives.

Are there concerns regarding the recruitment in the care sector?

Unison has a long-standing relationship with Cornwall Care and they had indicated that they were considering not providing care at home packages, however they have negotiated a temporary reduction in the hourly rate pay to staff. This has now increased to £7.60 after a period of six months and has not quite reached the level of the Living Wage yet.

A number of staff have left the care sector reluctantly, and there is concern amongst the remaining staff that care packages are being removed due to the lack of resource and this has had an impact on the individuals providing and receiving the care.

Are you aware of any measures being taking to address the concern raised in relation to workforce recruitment and retention?

There are short-term steps being taking including the introduction of the Spine Provider to step in where no other Provider is available to fulfil the care package,
there is also work being undertaken within the sector to achieve the guaranteed ethical standard charter. The Employment and Skills Board are currently looking into the training needs of staff and what can be implemented to ensure there is career progression within the sector.

All parties within the care sector are being brought together to develop a wider training strategy. The number of people requiring care is increasing with the ageing population and there needs to be an adequate number of staff to deliver the care, therefore action is required now.

*How do the employees feel about the Framework contract?*

The employees have a limited understanding of the bid process and the contractual arrangements associated with it and as such blame their direct employers for the issues.

*Has there been any improvement in communication?*

The Council has made the decision to become a living wage employer for both directly employed staff and contractors alike, staff need to be paid for their travel time between clients and have paid time to attend training but there are a variety of pressures on the Councils budgets and in turn this pressure is placed on the Provider.

The first Ethical Care Standard charter has been signed within the South West with the Council Providers and it is hoped that this will be a catalyst to set and increase the standards within the industry. However it is onerous on providers and there is a perception that the Council are treating its own Provider differently to the external Providers.

*What is your view on the communication between parties?*

The Unions had very little input into the Framework contract despite having a good relationship with the Council. We attend weekly informal and monthly formal meetings with the Council, however there was no information shared regarding the contract.

There is now a different Portfolio Holder responsible for Adult Social Care and we believe that the Council is a more open to work with the Providers, however, the Unions would like a greater involvement in commissioning as they have a relationships with a large number of employees across the sector.

*Do you think the process has put people off the sector?*

The people who were employed at the time did not fully understand the process, and the Non-Framework Providers and Framework Providers have all been impacted directly by the implementation of the Framework and this in turn is impacting on the people who are receiving care.

*What do you think could be done to improve the sustainability of the workforce within the sector?*
An increase in the rates of pay would assist, the people in the care sector do not do it for the remuneration, as it is primarily a moral choice. However, the care sector is competing with other industries that can pay better wages for less responsible positions.

In the future, there is a requirement to recruit a large number of people in the sector and the Council needs to look at setting the standard and make it a career that people want to enter into and progress in.

All organisations within the sector are experiencing issues with recruitment and this coupled with the increases in agency fees as led to the sector recruiting people from outside the UK, however this is a short term stop gap and we should be looking at growing the workforce within the UK and making it a more attractive proposition.

What is your view of a single integrated approach and how can you aid the understanding of the single approach?

In my view, the principle of Commissioners and Providers does not work, as it is over complicated. There needs to be an integrated approach to commissioning and a reduction in the number of Providers. Currently there are many small Providers competing for the same pool of staff and care packages, which means there are no economies of scale.

There needs to be more cooperation between providers and the Health and Wellbeing Board could assist in supporting the sector.

The big challenge is combining the constituent parts of Health and Social Care, what involvement have the Unions had in the process currently being undertaken?

The Unions have been involved at the initial stage through the Case for Cornwall on an informal basis, however, there has been no subsequent involvement.

Is there anything that you would like to add by way of summary?

The issues within the care sector are broader than issues that relate to the Council. The care sector currently absorbs most of the training costs for its staff, and a proportion of these staff that will enter the care sector as a stepping-stone to nursing and other roles within the NHS. The situation will be further impacted by the removal of the bursary available for nursing course.

There needs to be a sector wide approach to staff training and the development of career pathways that are subsidised by all areas of the sector including the NHS.

10.00 - ROYAL CORNWALL HOSPITALS TRUST
(Agenda No. 4)

HSC/24 By way of introduction could you provide us with your name and details of your connection with Care at Home provision?
I am Paul Bostock and I am the Chief Operating Officer for Royal Cornwall Hospital Trust.

How do you think you will cope with winter pressures, and will the changes being made in the Care at Home Framework impact on this?

The Treliske Site struggles to meet the current emergency demand, however the proposed changes in the Framework should allow more patient flow, and if the proposals are delivered the situation should be improved.

Do you believe the system to be more robust this year when compared to previous years?

We are much more aligned with other agencies and are aware of the issues. There is still an issue with capacity, however there has been an improvement due to the better working practices.

Has the process for people flowing through the hospital improved?

The Emergency Department now has an acute General Practitioner assessing the patients coming into the department, which is assisting with the patient flow at the front end of the process. To improve the patient flow at the back end of the hospital there patients need to be discharged at the earliest opportunity and this is not always possible due to there not being a suitable care package in place. Communication between all partners needs to be improved to enable care options to be discussed and put in place at an early stage reducing the number of delayed discharges.

Is there a structure in place for arranging onward care to allow patients to be discarded from hospital?

There are issues of our own making, which we are trying to resolve regarding the time that patients are discharged and there are issues in relation to capacity of care Providers that is not within our control. We now have a more robust process in place and are interfacing with our partners to improve the patient flow.

In your evidence you referred to an acute GP being based in the Emergency Department, is this part of a wider strategy and is RCHT having an impact on flow issues?

There is a Multi-Provider Group that meets to review the pathways and look at the ways people can be treated by other parts of the NHS. The strategy is about ensuring that the right expertise is accessible at the right time in the patient journey. It is felt that the acute GPs fit into this strategy as they have the relevant experience to assess people when they first present to the Emergency Department.

How much do you involve carers and families in discharge decisions?
Every patient that comes into the hospital is assessed and given an expected discharge date. To date we have not been good at informing families at an early stage about the care options especially where the preferred option is not available. We are currently focusing on working with our staff to promote early conversations with all parties and are looking at bringing forward discharge dates for more simple cases.

*As NHS providers, what do you think is your role in Care at Home?*

Our role is to communicate and brief patients about the options available for their care to prepare them for their transition back to the community and to work with our partners to put in place a suitable care package.

*Do you believe the process was better prior to the Framework?*

On face value, it looks like there has not been any improvement as there are 56 people currently in hospital that could be transferred and this is double the national average. There is a plan in place that will come into effect in January and it is anticipated that this will reduce the number of patients who cannot be transferred. The question is, ‘What are the issues impacting on discharge across the totality?’ The Royal Cornwall Hospital Trust deals with people with complex care issues and these people require more complex care packages when they are discharged into the community and currently not all of the packages can be provided at the point of anticipated discharge due to resource issues. The other issue is with the families of the patients receiving care, that believe that the best place for their relative is in hospital as they do not have confidence in the alternative options.

*Are there differences between how you liaise with those receiving long-term complex packages of care and those receiving a ‘traditional ‘care at home package?*

Cases that are more complex can now be treated within the community so finding Providers who can deliver the right level of care can be an issue and these cases often require a bed in a nursing or care home prior to going back to their own home. The number of beds are limited which adds an additional complexity to the case as it is not just about the package of care but locating suitable accommodation.

*What changes have there been in the discharge process where Care at Home might be needed?*

The discharge process is one of the many steps in the patient journey and there are number of things that can be done to make this process as smooth as possible. Assessing the patient at an early stage in the process to ascertain their requirements following there discharge is the first step and a specialist nursing team work with vulnerable patients and case manager their care throughout their hospital journey.

There has been significant work done in relation to the discharge process and now there is an expectation that all patients have a date for discharge, which is reviewed throughout their journey. In addition, there is a twice-daily review of
all discharge dates and any patients that are identified as being due to be discharged are prioritised to ensure that everything is in place to support them when they leave the hospital.

There is a piece of work currently being undertaken that will move patients ready for discharge from the hospital bed into a discharge lounge which will allow the hospital to use the beds for other patients, while giving the patients awaiting discharge a safe place to stay until they can go to the agreed place within the community.

The Hospitals performance on the length of stay is good in comparison to other hospitals, however it is recognised that early communication with patients, their families and partners in the hospital journey with regard to care options and expectations for the patient discharge can reduce the length of stay in hospital. Ongoing communication with all parties and the sharing of accurate details throughout the process is the key to achieving a timely discharge.

**What changes have there been and do you think they have gone far enough?**

There have been two recent inspections, one relating to the business side of the Emergency Department, and one that looked at the discharge of patients. In my view, it is all about the speed and pace of change. My concern is whether the changes are radical and rapid enough. There is a real risk to care from the business of the hospital and we have to look at why the changes are not improving the overall performance.

**Do you think integration will help improve the issues?**

Integration needs to be the vehicle to change the whole way of working and improve the experience of care for the patient. It comes down to a question of money, budgets are being reduced and this requires us to look at how we work in all areas and by looking at care as a whole without focusing on who delivers it presents an opportunity to tackle budget issues and review how care is delivered.

**Have NHS Providers been proactive in resolving situations where able?**

We have taken some proactive steps to support the ongoing care of patients for example, when a stroke patient is discharged from hospital a team is assigned to provide therapy at the home of the individual and we are looking to extend this to other areas, such as orthopaedics.

**How long do you provide this care for and what process is in place for the handover of the care to another provider?**

For orthopaedic patients the handover takes place around three or four day after discharge. We are currently looking at how this approach can be adopted for other pathways.

**When bed blocking arises are you proactive to help?**
When planning for the winter pressures we look at measures that can be put in place to mitigate the issues that cause bed blocking. One of the measures we are looking at is identifying other areas where we can extend the acute care at home.

We meet weekly with Care at Home Providers to ensure we are all working together. We also review the work that is going on around the country to alleviate the issues and investigate any options that may be suitable for Cornwall.

*How has communication been between those involved?*

A lot of the community and Care at Home staff from the Peninsula Trust are based on the hospital sites, which aids good communication between the parties. We are now working from one list with the PCT, which has also been an improvement.

There are inherent frustrations with communication with staff working in the rural locations, however this is partly due to capacity in these areas.

*Are you involved in the training of carers?*

I think that the biggest step forward has been in the area of training support workers, as there is a lot of bedside care provided by support workers. There is a wider piece of work being undertaken that involves, partners to identify training opportunities and career pathways for carers.

*Do you have concerns about the pool of resources being shared between yourselves and care Providers and the impact this might have?*

The integration of services for our care workers needs to sit with the Care at Home Providers and does not necessary sit with us, however a flexible skilled workforce will be of benefit to us.

*Who is to lead on the integration?*

There is an agreed workforce plan that has identifies senior officers who have been assigned to lead on the work. There is a piece of ongoing work to scope what Health and Social Care integration looks like.

RCHT are providing input and making suggestions of areas where we can make improvements across the integrated services and we are relying on other partners to have input in the areas where they provide specialist services. For the integration to work there needs, to be strong and clear leadership and the work needs to take place at pace.

*Where should the drive and lead come from?*

For the integration to progress, there needs to be buy in and engagement from staff, patients, their families and the wider public. The leadership needs to come from the top of the organisations with Social Care and all other partners leading on their areas of speciality.
By upskilling your staff do you believe there is an impact on other areas providing care?

This is an example of where we need to look at sector wide career pathways. We would be happy to discuss this issue with Adult Social Care to identify a way we can work with staff to reduce the impact on resources. We need to move from the current competitive approach and focus on what is best for the community.

In your view, does the Living Board set up in the Penwith area help with providing care in the Community?

Small-scale community projects of this nature help break down the barriers and unlock some of the budget and money constraints as well as fostering accountability in the local area.

Is there anything that you would like to add by way of summary?

To resolve the issues that are being encountered, we need to have a robust plan in place that we can all put into action and deliver the care in a joined up way.

10.45 - PENINSULA COMMUNITY HEALTH
(Agenda No. 5)

HSC/25 By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

My name is Steve Jenkins and I am the Chief Executive of Peninsula Community Health (PCH).

How do you think the system will cope with the winter pressures, and will the changes being made in the Framework impact on this?

The position of the PCH and the overall system has improved over the past year. The PCH has now established an onward care team and have developed one list of patients requiring care that is also used by RCHT.

We have daily communication with the hospital to discuss cases and the requirements of care packages for individual patients to enable them to be discharged into the community at the earliest opportunity.

The acute GPs that are now working in the Emergency Department at Treliske, allow patients to be triaged effectively at the first point of contact within the hospital and the increased capacity of the onward care team assists with the early discharge of patients, aiding patient flow throughout the hospital.

There is a lot of work going into addressing the length of time that a patient spends in hospital and we are pleased to see an increase in the money going into the Care at Home sector and this has established the market however, it has not resolved the issues.
As NHS providers, what do you think is your role in Care at Home provision?

I think that the identification at an early stage of patients requiring ongoing care when they leave hospital is important and to support this the onward care team are assessing the needs and liaising with the Adult Social Care team to ensure they are aware of the care needs.

There are currently 1000 district nurse visits every day, they have a very good relationship with care homes, and these relationships need to be built upon and used effectively.

Our involvement is across the board and we have offered staff to work in the Steps Team, which will hopefully be in place from January onwards.

Do you believe the process was better before the Framework was put in place?

I personally have only been in post since 2013, therefore am unable to comment beyond that. We are seeing the amounts pay to Providers reducing but the pressures are increasing, including the increased amount of management time spent on dealing with complaints, which is taking time away from the providing of care. I do believe that the cost effectiveness of providing Care at Home can be increased by reducing the number of Providers, as it currently stands there are too many providers competing for work and resources on reduced profit margins.

Are there differences between how you liaise with those receiving long-term complex packages of care and those receiving a ‘traditional’ care at home package?

There has been no difference in the way we liaise, as each person’s care needs are different and they should be seen as individuals.

What changes have there been in the discharge process where care in the home might be required?

We have improved our own systems, including working from the same list as RCHT, the development of the Living Well Programme and strengthening the onward care team. There has also been more involvement from the voluntary sector as they can provide support to get people back into their homes, specifically providing support such as a befriending service.

What will lessen the impact on community or hospital setting, and how will this improve the outcomes for care users?

The whole Care at Home system is under a huge amount of pressure. The addition money that is been provided to the Lot One Providers has helped to stabilise the situation, however there is an issue with the recruitment and retention of staff and we need to work on providing career pathways and a clear career progression structure within the sector.
Community hospitals are a good place for training people in the care sector as they can learn the skills needed in an environment where there is the required support before they go out to provide care in the wider community.

**Have NHS providers been proactive in resolving situations where able?**

Over the last year, there have been some very creative solutions to assist in mitigating the issues that have been encountered. The Council have agreed to block book beds at the Community Hospital that builds more flexibility in the whole system.

There is a resource issue, which means it can be difficult to get care packages in place and the district nurses have been used in some circumstances, which has an impact on other areas.

The working relationships between all parties are much improved and to fill the gap there is a strong desire across all parties to put the care of patients first and the introduction of the Living Well Programme has provided more scope for improvement.

**How has the communication been between those involved?**

Two years ago, the communication was dire and there was a blame culture between the organisations. However over the last two years there have been significant improvements and an appetite from all parties to make improvements, for example, the NHS has taken the lead on communication with people about making the right choices when considering where to seek their care from and this is reducing the impact on the front end of the Emergency Department.

Partners now have respect for each other and are able to provide constructive challenge and a shared responsibility as it is now accepted that the whole system needs to work well to improve patient flow.

**Are you involved in the training of carers?**

We do provide a lot of training already, where Care Homes require their staff to be trained, we make Practitioners available to provide this training and provide advice and support in relation to end of life care. However, we do not currently provide training to the wider Care at Home sector in a formal way.

**Is there a way that we can rebrand the caring profession?**

The role of home carers is important and without them there would be a lot more pressure on hospitals, therefore it is in the interest of the whole sector to find a way of promoting the role and making it more attractive.

**Do you have concerns about the pool of resources being shared between yourselves and care providers and the impact this might have?**

Cornwall requires a five-year Strategy that links a variety of areas, for example, we do not currently work with housing, however the lack of suitable housing in
the community will have an impact over the longer term on the length of time it takes to discharge from hospital. Having a clear strategy and standards in place will allow the partners to prioritise the aspects that they need to deliver on and ensure there is a joined up approach.

Who do you think should provide the leadership for this strategy?

The PCH has been the glue holding the sector together and we have been instrumental in moving things forward. All parties need to undertake the work at pace utilising the good work that has already been done.

Is there anything you would like to say in the way of summary?

We need to look at the issues we have experienced in the past and use the learning from them to deliver the best care possible in the longer term.

11.30 - CORNWALL PARTNERSHIP FOUNDATION TRUST
(Agenda No. 6)

HSC/26 How do you think you will cope with winter pressures, and which of changes made could make the biggest difference?

The time of day that a patient is discharged from hospital can make a huge difference, for example, discharging a dementia patient at night can mean that they have to go into a nursing home to gain support rather than being released from hospital into their own homes, which would happen if they were to be discharged during the day.

More capacity on the ground is required to avoid the situation were care Providers are unable to provide care packages. We currently attract home care staff to our organisation because we pay higher rates than the other Providers can pay, however we are aware that we are all competing for the same staff and there needs to be some consideration given into how this is going to be sustainable in the future.

There needs to be an opportunity for carers to progress their careers where they want to, and for the carers who are happy with the role they perform they need to be recognised for their work and for their work needs to be valued. The approach needs to be joined up throughout the sector and we need to be more creative around issues such as staff training.

As NHS providers, what do you think is your role in Care at Home?

We have a Section 75 resource agreement. Predominantly patients will have physical conditions, however, there are some patients who have dementia or other mental health conditions, can require care that is more complex, and our role is to support the Care at Home delivered through the district nurses etc.

Do you believe the process was better before the Framework?
On the face of it, the Framework was a good idea but there was concern expressed regarding it being structured on a cost-based system. As a trust we did not believe that it was viable to provide care based on the specification of the tender therefore we did not bid for inclusion in the Framework.

Following the implementation of the Framework, the Framework Providers have not been able to meet the demand for care packages therefore the Council has not been able to enforce the terms of the Framework and as such, the Framework is not working effectively.

Do you think that there are things that could be done to prevent patients from being moved from care facility to care facility?

We need to be better at providing nighttime support for dementia care and when people are moved out of their home and into a care setting they can be caught in a vicious circle. The introduction of the Living Well Programme may contribute to improving this issue.

Are you involved in the training of carers?

A cross agency approach to training would be welcomed. Currently the dementia nurses that work within the Trust provide informal training to care homes and we provide guidance and support to mental health units. There are plenty of jobs in the care sector however, there are not enough people wanting to take up the roles.

There are many students taking Health and Social Care courses at the college but concern has been raised that there are not enough work experience placements available, could you provide comment?

As far as I am aware the CPFT have not been formally approached by the education providers to discuss work experience placements.

Do you have concerns about the pool of resources being shared between yourselves and care providers and the impact this might have?

We need to work together within the sector and look at how we can all work more efficiently. There needs to be a place based approach to provision and there should be an element of control over the provision from the local community. Post April we are looking at working with clusters of GP practices to identify where demand for care is and are looking to engage and support the voluntary sector. The wider challenge is to make communities more resilient and to put in place a structure that is right for local communities.

Who do you think should provide the leadership?

We have a plan of work to do up until April, in addition, we have a transformation team in place that are working on drawing up plans and working with providers to agree actions to deliver care effectively.
By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

I am Peter Stokes and I am the Chief Operating Officer for Kernow Health. I represent 165 Doctors practices in Cornwall and the organisation was formed to ensure that the voices of practices were heard and that they are sustainable for the future.

How do you think you will cope with winter pressures, and will changes being made in the Care at Home Framework impact on this?

There is currently a crisis in GP practices, there are not enough GPs, and there is a shortage of practice nurses. 65% of GPs aged 55 or older have indicated that they will be leaving their jobs in the next 5 years. The workload of GPs has significantly increased and one of the contributing factors is providing care in the home. It is acknowledged that older people respond better to care when they receive the care in their own homes, however this type of care can impact on GPs.

There is a realisation that there is not a silver bullet to resolve the issues and things need to be done differently.

How can the issue of sustainability be improved?

Kernow Health are providing a strategic voice, sit on the System Resilience Board and are working more closely with partners at a senior level.

We have been successful in bidding to become a community education provider network and will be delivering this jointly with Devon.

Partners are pooling resource and working in a portfolio model, which is allowing GPs to gain more skills and work in different areas for example, working for 2 days a week in acute care within the Emergency Department.

Are the Care at Home Services sustainable?

Currently, if a care package cannot be delivered it has a direct impact on GPs, for example if a patient requires eye drops and there is not a carer available to provide this care, GPs have been asked to do this. Unscheduled GP visits, due to the lack of a care package, place an additional burden on practices. Therefore, it is crucial that the home care provision is strong.

The Care Provider needs to be encouraged and supported to provide care training and the GPs have a role to wrap around this training.

When do you see that a plan will be in place for the provision of care and who should lead on it?

I see that the Deal for Cornwall and the integration of Health and Adult Social Care will be the driver for this and we welcome the combining of resources. This will allow people from the various partners to work more closely together and
the Providers are now more receptive to joint working, which will impact on the way care is delivered, and the collation of GPs is leading the debate in relation to effective partnership working.

*What will lessen the impact on community of hospital settings, and improve outcomes for care users?*

All the right things are being put in place, the most immediate thing we are doing is investing in staff training and looking at where the various roles fit into the overall care picture. Well trained staff will help reduce the current issues in the longer term.

*How is the communication been between those involved?*

Communication at the strategic level and on the ground was good. There could be some improvement in the communication between multi discipline teams and operational teams, however the relationships are now much stronger and there is more trust between all parties.

*Are you involved in the training of carers?*

The NHS had put money into creating more opportunities for community education, which will allow us to act as a vehicle for the delivery of more joined up training. We are working with Exeter and Plymouth Universities and other education providers to develop the training.

*What role do GP's have in Care at Home provision?*

We need to ensure that there is sufficient resource and skills available to deliver the care required in the community. If the resource is not maintained it will put further pressure on the GPs service, which is already under pressure.

*Do you think there is the required capacity within GP Practices to undergo the radical changes that are required?*

GPs have recognised the need to change and there is a mandate amongst the Doctors. Not all of the 65 GP Surgeries are on the same page as some of them are very traditional but they are in the minority. The majority are embracing the change and providing the required leadership in their practices. Although it is going to be challenging to keep business as normal progressing while the work to transform the service is taking place.

**13.40 - NHS KERNOW**

(Agenda No. 8)

HSC/28 I am Trevena Doyle and I represent the Kernow Commissioning Group and we are responsible for systems resilience, safety, and patient flow, which includes the capacity of Care at Home provision.

*How do you think the system will cope with winter pressures, and will changes being made in the Care at Home Framework have an impact?*
Anticipating some of the periods of pressure and being realistic about the demands on provision I believe that overall, the system can perform well. The 4-hour target is consistently being met in Minor Injury Units, system partners meet on a regular basis to develop plans to meet the needs of patient flow, and the respective regulators sign these off.

The key objective is to maintain the patient flow system. Long stays in hospital are a large contributory factor to the deterioration in the ability of a person remaining independent in the community. The needs to be the required capacity in the Care at Home provision to enable people to leave hospital with the right care in place at the earliest opportunity. The introduction of the Steps Service combined with Care at Home provision will assist in meeting the winter pressures.

What examples are there of national good practice and would the models in Cornwall compare with examples?

There are a variety of initiatives that are taking place in Cornwall such as the Living Well Programme, which is helping assess people’s needs at an early stage. The Programme is centred on getting people the right support in their community and the Steps Service, that provides short-term support that is goal orientated and where this service has intervened there has been an increase in the number of people staying in their own homes.

However, there is a lack of capacity in the Steps Service, which means that the service is unable to take on all the referrals and requires domiciliary care to input more resource.

Integration with the rapid response services is required as the evidence shows that this reduces the requirement for long-term care.

There has been a change from long hospital stays to providing more care in the person’s home. Acute care can now be delivered in the home and the processes to facilitate this can be put in place but to make them work there needs to be a change in culture and thinking.

What procedures are in place for when people leave hospital and are not sure whether they can cope in their own home?

The best practice is for someone to come into hospital who had not previously required a care package and there would be an assessment done while they were in hospital to assess their care needs and a package would be put in place for when they leave hospital. This package would be assessed after 24 hours of their arrival home to ensure that it meet the needs of the individual.

In the evidence that you have provided, you advised us that where there is a greater intervention from the Steps Service there is less reliance on domiciliary care, please could you provide further clarification on why you believe this is the case?

Where there has not been enough capacity in the Steps Service the care package is provided by domiciliary care, the domiciliary care service provide less
intensive care, however the Step Service provision is more intensive and focuses on rehabilitation therefore the patient outcomes are different.

*How do you see the sustainability and modernisation of care at home services and your role in it?*

The key element is working to balance the day-to-day services with the transformation work, as these will have to be done in parallel. Patients want more choice and control over how their care is delivered and with the introduction of direct payments, the way services are Commission’s needs to change and be modernised.

*How do you make it sustainable?*

To make it sustainable we need to look at using our resources better, ensuring that the workforce is not fragmented across the providers and that the work is not duplicated. The integration of teams and services will assist with this and avoiding duplication, in addition to helping to achieve the required savings.

*Will you be altering from spot purchasing packages in foreseeable future?*

Spot purchasing has been done for a number of years by frontline staff. The question is what model of care do we want to Commission? This will drive how we will purchase the care but in the meantime, we will continue to spot purchase.

*What was the NHS approach to contracting Care at Home packages in 2012-2014 and what is it now?*

The Providers applied for individual packages of care and recently, there has been an introduction of the health buyer session, which looks at the length, and hours of staff service, we are now looking at a whole picture model. As it is a bidding process, we do not set a fixed rate for care packages.

*Will the steps being taken in terms of pricing and a Spine Provider Provision be sufficient to support and enhance private sector Care at Home provision?*

There is some nervousness about the delayed transfer and to date there has not been any improvement. The price increase paid to Providers by the Council has created some resilience in the sector and there is an expectation that improvements will be seen in January.

*Have you concerns about the recruitment and retentions of the workforce involved in care and if so, how will you help with this?*

The System Resilience Group has been looking at this issue for a long time. One of the issues is how to introduce Steps and Core Care provision without taking resource and disabling other Providers.

There is a requirement for the whole sector to work together, and look at training people to carry out roles, and have the flexibility to allow people to do
work placements or rotations in a planned way to present the maximum amount of opportunities for the workforce to develop.

**Is there an agreed action plan for this approach?**

The current focus has been on the here and now. We need to map out what we currently have and understand where the skills gaps exist and start addressing the issues.

**How has the communication been between those involved?**

The communication is good and consistent and I have received some good feedback. There is support between the partners and they provide each other with a high amount of challenge. The Chief Officers are meeting on a weekly basis and the focus is centred on providing the best care for the patient.

**Is there something that you would like to add by way of summary?**

The key question is about how we commission care in the future to meet the growing demand in a way that is efficient and effective.

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**15.10 - CORNWALL COUNCIL (EDUCATION, HEALTH AND SOCIAL CARE MANAGEMENT)**

(Agenda No. 10)

HSC/29 I am Anna Mankee-Williams the Head of Service (Commissioning, Performance and Improvement), I am Maria Harvey, Senior Manager, Contracts and Service Improvement, and I am Liz Nichols, Senior Commissioning Manager.

**How do you think you will cope with winter pressures, and will changes being made in the Care at Home Framework have an impact?**

One of the key things that the Council and its Partners need to do is to analyse and address the demand. The situation in Cornwall in relation to demand is similar to the national picture and we are working to put in place mitigation to deal with the here and now and reduce the impact of the demand. There are a variety of measures that we are looking to put in place that include, conducting soft market testing for a welcome home service that would be done in conjunction with RCHT. We are looking to improve processes and work more closely with RCHT to develop a common process methodology and a clear plan has been developed to support this with the Council taking the lead. We are currently looking at bringing in a single line management model with the CCG and are looking at introducing a trusted assessor role, which would mean that an independent person would assess patients care needs and feed into the care package requirements.

We are working with the voluntary sector to provide support for people when they leave hospital to ensure they have day to day support with tasks such as shopping and pastoral support.
To reduce the immediate pressure, the Council has opened a four bedded care provision for the Christmas and New Year period to alleviate some of the issues when the demand is at its highest.

We are working more closely with the Providers and are listening to suggestions they put forward and taking on board the issues.

With the introduction of direct payments, people are able to select Non-Framework Providers to provide their care and the Council is working through checking all new Providers for quality.

We also have the provision of two flats that can be utilised and need to communicate the details with partners so this provision can be used effectively when required.

**Is there good communication, and are partners joined up on the back door provision?**

There has been a plan developed for all partners and in addition to the work being done on the back door provision a cross agency group is working on reducing hospital admissions, which will reduce the pressure on the back door provision.

There has been investment in equipment with a view that some double care packages can be reduced to single packages to free up capacity.

**What is the impact on care users and how do we know what will improve outcomes for care users?**

The first thought when providing care provision is with the services users, we conduct questionnaires, hold focus groups and gain feedback on a face-to-face basis. The tender included questions regarding the ethical care charter and asked bidders to provide a method statement feedback from their service users. In addition, we have an electronic monitoring facility and are in contact with the people who received care as they telephone the Council on a daily basis.

**Will the steps being taken in terms of pricing and the Spine Provider Provision be sufficient to support and enhance private sector Care at Home Provision?**

The Spine Provider has been established in response to the issue of demand outstripping the capacity of the Providers and will help meet the need from more complex care packages. This provision has only been in place for a short amount of time, therefore will take some time to have an impact.

The pricing has established the market and will help in establishing the workforce, however there is still work required to look at ways to attract people to work in the sector.

Currently the Health Care Assistant roles attract more applicants than there are roles while other roles in the sector do not attract applicants, and the reasons for this need to be understood so we can address the situation.

**How will the variations between Lot One and Lot Two be addressed?**
The setting that the care is delivered in is different and there is the additional travel element with the Lot One packages, however the transactional process is the same for both Providers Lots.

In your view, are there substantial differences in the care packages provided by the Lot One and Lot Two Providers?

The Providers were split into two lots, as they are different due the nature of care they provide, however, there are minimal specific differences between the two.

How is the voice of the person in receipt of care (and their families) heard?

The Council has an engagement officer who works with the care providers. Historically the engagement has been with the same people and there is recognition that the Council needs to engage with a larger number of people in receipt of care and there is a specific piece of work being undertaken to look at how this can be achieved.

What is being done to help Providers regarding workforce training, recruitment, and retention?

There has been £10,600 of funds put into a recruitment campaign, we are working with colleagues within the sector, and with the LEAP to attract European Funding, we have held workforce development sessions to promote good practice and have developed a strong relationship with Job Centre Plus.

There is work being undertaken to develop career pathways with clear case studies to illustrate the opportunities available, and linking with qualifications that are now requiring a year of experience in the care section. Job Centre Plus has care sector champions within their offices to provide quality advice for job seekers. Training has been commissioned to train managers and provide the mandatory training required in the sector.

There are wider things that are happening such as an award ceremony for people within the wider sector to recognise the positive achievements, providing support with accommodation and developing a scheme of discounts for staff within the sector.

Do you foresee a return to a method of spot purchasing packages rather than commissioning care through a Framework?

The Framework is in effect a formalised way of spot purchasing. The option of block purchasing care has been looked into, however with the introduction of direct payments this option would not have the flexibility to meet the care requirements.
HSC/30  

By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

I am Julian Kitto, Assistant Head of Governance and Information - Legal Services and Wayne Rickard - Assistant Head of Finance at Cornwall Council.

What are the main issues legally that were raised by the initial challenge to the Framework and how were they addressed?

The issues that arose related to the unpublished sub set of data in the scoring matrix that was designed as guidance for the tender process and informed the weighting. Once the tenders had been scored, the bidders were informed of the outcome and the unsuccessful bidders requested feedback as to why they had not been successful.

Following the feedback there was a challenge to the tender during the standstill period regarding transparency of the process, which specifically related to the publication of the criteria, and the challenge was lodged in court, which halted the appointment of successful bidders.

The challenge put forward, claimed that as the weighting criteria was not published, the process was not transparent, and it was alleged that if the information had been made available it would have impacted on the bids submitted. The view was taken that the chances of defending the Councils position in court was poor and therefore the decision was made to agree to a consent order and settle the case.

The Council could have then chosen to go back to the pre-qualification question stage of the procurement, however it was felt that there had been learning that could be applied to the process and the Council put out a new tender.

How was the guide price set and how can the Council seek to support the market who now finds that unviable?

There was a guide price of £14.50 set and this was not presented as a ceiling rate of pay. The information gained during the first procurement and the prices obtained from domiciliary care invoices paid across the county were used to calculate the range and formulate the guide price. The information was also combined with the requirement to make efficiency savings.

Since the Framework procurement, the Providers have made representations to the Council regarding the rates and sustainability of the contract. Regular meetings have been held with the Lot One Providers to discuss the issues they were experiencing with the Framework and there was a range of measures put forward to mitigate the issues. One of the main issues that the Providers put forward related to the volume of care packages that they were receiving from the Council. The number of packages fell far short of the projective number suggested in the tender process and this had an impact on the Providers as they could not make the required economies of scale to meet business costs. Moreover, various Providers had indicated that they would withdraw from the Framework and the sector.
Following the concerns being raised regarding Lot One Providers and the evidence produced to support their case, Cabinet agreed additional funding of £4.5 million pounds to fund an increase in the hourly rate to £16.00.

**Do you believe that the increase is sustainable and how will the Spine Provider impact on the Providers?**

The Spine Provider has been establish as a Provider of last resort, therefore it is not envisaged that they will be completing for the care packages with the Framework Providers and not impacting on the economies of scale and meaning the uplift in the hourly rate would be more sustainable.

**When the Council agreed to increase the hourly rate paid to the Lot One Providers, was the introduction of the living wage taken into consideration?**

The report to Cabinet looked at all the latest information available regarding an hourly rate for Domiciliary Care and the current rate paid in the South West was on average £15.85 so in setting the rate at £16.00 takes the rate that the Council pays to the Lot One Providers above the average.

In announcing the introduction of the National Living Wage, the Government stated that there would be tax breaks in place to support businesses in making the transition to the new wage and envisaged that there will be future challenges that will need addressing including the volume of care packages available to the Lot One Providers.

**What due diligence took place in the contracting/procurement of the Framework?**

There was consideration given by Adult Social Care as to what other Councils were doing in relation to the domiciliary care provision and there were supplier events held where the Council engaged with the representatives from the market. Assessments were made at the pre-qualification stage of the tender process, there was engagement with solicitors throughout the process and they was legal support available at the contract-signing event.

Following the signing of the contracts there was an implementation meeting and a contract review meetings were held. Throughout the process, the Council provided and shared responses to all the clarification questions posed by the Providers.

**How will the Council fund any overspend in this area and how will it impact on other services?**

There is a requirement for the Corporate Directors to fund any overspend from within their Directorate, however in this case the decision was made corporately to add £4.5 million pounds to the budget to resource the year on year demand. A longer-term strategy will be required to address the budget issues going forward and this will have an impact on other services in the directorate, as domiciliary care was a priority service provision.

**Could the Council share the list of providers and bid rates?**
The list of Framework Providers was in the Public domain and detail could be supplied to the Committee in writing. Each of the Providers submitted an hourly rate of pay during the tender process, therefore each one is paid at a different rate, and this information was not available in the public domain.

*Have lessons been learnt in order to inform future commissioning and budgeting plans?*

An annual business plan and annual accounts are produced by the service and the information from these help the Council gain an improved understanding of the market and ensures that the Council is conforming to Act One of the Care Act.

Lessons have been learnt with regard to staffing, at the outset of the procurement the Council requested details of the employees working for the Providers with the view that TUPE arrangements could be put in place. This is not information that the Council can compel the Providers to supply and as the domiciliary care market in Cornwall was underdeveloped the engagement and the relationship with companies was not established enough for them to share the information. In future tenders the market will be more developed and the relationship will be more established which would resolve the issue.

Due to the current amount of capacity within Care at Home provision, there is no way to enforce a default escalation process and the Council is not able to exclude any of the Providers from the Framework.

*Will the steps being taken in terms of pricing and a Spine Provider be sufficient to support and enhance private sector Care at Home provision?*

It is too early to assess the impact of the increase but it has established the situation. The hourly rate paid to the Provider is only part of the issue. The private domiciliary care market in Cornwall is relatively immature and small and medium companies deliver care provision in the main, which makes the market very sensitive to external and market changes and changes in the workforce. The increase in the hourly rate has assisted in building a better relationship with the Providers and in the ever-changing market, the Spine Provider will help provide more stability especially in the event that a Provider is unable to provide care packages or exits the market.

*Was there adequate legal and finance involvement in the development of the Framework?*

Legal and finance support was provided throughout the procurement process, however in hindsight the first unsuccessful procurement had not received the right level of support. There was only a small amount of support provided, a senior solicitor reviewed the details in the draft contract and there was limited ad hoc support and this had contributed to the failure of the procurement as legal had not been aware of the sub criteria used to weight tendered bids.

As the first procurement had not been successful, this placed more importance on the second procurement being successful and it had to be carried out at pace to ensure that there was a Framework in place. The Council commissioned
external solicitors to draft the paperwork, there was a lot more internal resource from legal, and finance assigned to the process. The Council dealt with the threat litigation internally and the Head of Governance and Information chaired a project board that meet on a weekly basis and helped to ensure that the focus was maintained and that there was an overview of the identified risks. For future procurements, there is a recognition that the Council needs to obtain a better understanding of the market and the pressures that the providers face.

*If the modelling had been done at an earlier stage to the procurement, do you think the guide hourly rate would have been set at the current rate of £16.00.*

The lower hourly guide rate was set based on the evidence collated at the time and to meet the budget pressure being face by the service, therefore the modelling would not have had too much impact on this. It is also in part an issue with the maturity of the market in that when the Providers submitted their bids there was the option for them to put in a higher rate based on their business models.

The meeting ended at 4.20 pm.

[The agenda and reports relating to the items referred to above are attached to the signed copy of the Minutes].
**Witnesses**

The Health and Social Care Scrutiny Committee would like to place on record its
gratitude to all the witnesses that attended the review and who provided
evidence in a coherent and comprehensive way. Their evidence has enabled the
Committee to gain a broader understanding of the issues and make
recommendations.

The list of witnesses is set out below, in the order in which they appeared before
the Committee.

**DAY 1 –**

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<th>Witnesses</th>
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<tr>
<td>Cllr Jim McKenna</td>
<td>Portfolio Holder Adult Care, Cornwall Council</td>
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<td>Ian Williams (Cornwall Care)</td>
<td>LOT 1 Providers</td>
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<td>Kevin Taylor – McHale (Taylors of Grampound)</td>
<td>LOT 1 Providers</td>
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<td>Lyn Tomen (Brandon Trust)</td>
<td>LOT 2 Providers</td>
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<td>Tim Jones (United Response)</td>
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<td>David Smith</td>
<td>Cornwall Partners in Care</td>
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<td>Christine Rowberry</td>
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<td>Trish Berryman</td>
<td>Non Framework Providers</td>
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<td>Mary Anson</td>
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<td>Debbie Pritchard</td>
<td>Healthwatch Cornwall</td>
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**DAY 2 –**

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<td>Stuart Roden</td>
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<td>Paul Bostock</td>
<td>Royal Cornwall Hospital Trust</td>
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<td>Steve Jenkins</td>
<td>Cornwall Partnership NHS Trust Peninsula Community Health</td>
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<td>Phil Confue</td>
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<td>Peter Stokes</td>
<td>Kernow Health</td>
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<td>Tryphaena Doyle</td>
<td>NHS Kernow</td>
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<tr>
<td>Julian Kitto</td>
<td>Legal Services, Governance and Information, Cornwall Council</td>
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<tr>
<td>Wayne Rickard</td>
<td>Finance Services, Business Planning and Development, Cornwall Council</td>
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<td>Anna Mankee - Williams</td>
<td>Education, Health and Social Care - Cornwall Council</td>
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<td>Maria Harvey</td>
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<td>Liz Nichols</td>
<td>Education, Health and Social Care - Cornwall Council</td>
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Printed written evidence

Written Evidence Submission from LOT 1

Scrutiny Committee

1 / Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home?

No, the steps being taken are good ideas in their own right but they will fail at the point of delivery. Care at home providers have no choice other than to work on a high volume, low margin business model and the limiting factor that the majority of providers are battling with is their ability to recruit and retain enough carers to be able to run sustainable services.

The UKHCA state in their ‘a minimum price for home care’ guidelines that providers need to be paid £16.16 per hour for care in order for them to be able to pay the current national minimum wage (£6.70 per hour), which will increase to £16.70 per hour in April 2016 in order for them to be able to pay the new national living wage (£7.20 per hour).

The Council are currently paying providers on the framework agreement £16.00 per hour, which is not enough to enable them to pay their staff what is deemed to be the market rate of £7.10 an hour. It is also not enough for providers to recruit and retain sufficient numbers of carers to enable them to run sustainable services in what is in practice, a highly seasonal and low unemployment market place in the county.

The Council’s spine provider Corcare is currently paying its carers £7.85 per hour (the same rate the STEP’s team were being paid) and care at home providers are already experiencing carers transferring across to them due to the higher wages and associated benefits. Also, new and existing supermarkets are paying their staff up to £9.00 per hour for roles with considerably less responsibility, which will mean that carers will leave the sector.

2 / How do you think the system will cope with winter pressures?

The system will not cope with winter pressures. It is only a matter of time before our hospitals go back onto a back alert status and one of the main reasons why this will happen is that the Council have not put enough resources into care at home (despite repeated efforts from providers to address the issue) to enable providers to recruit, train and retain enough carers.
3 / You bid at a rate which you had established, what subsequently changed in order for the system to not work effectively?

Care at home providers based their bids on the information provided by the Council in the meetings that took place leading up to the tender process and in the tender process paperwork.

Providers were given a guideline rate of £14.50 on which to base their bids; some care package volume information dating back to October 2012; an understanding of how the 6 month mobilisation process work in practice and a sense that the Council wished to work with a smaller number of providers and that they would put steps in place to enable this to happen.

The Council stated that their finance team had modelled the £14.50 figure and determined that it was sufficient to meet all statutory requirements in respect of the national minimum wage, despite the UKHCA’s view that the cost of care at this point in time was £15.19. This led providers to believe that the Council would work them to enable this to work, which did not materialise in practice.

The care package volume information turned out to be misleading as it included care packages that were delivered by the EIS team, which was confirmed by a Council Officer as not being relevant to the process. The care package volume information also completely ignored the Council’s intentions to talk to clients about what they later described to be their preferred option, which was for clients to go onto direct payments, which had a significant impact on the number of care packages available.

The Council decided to continue to pay non framework providers the rates they were being paid prior to the framework agreement (£16.28), which had the impact of enabling them to pay their carers higher rates than framework providers and once combined with the fact that providers were unable to TUPE transfer carers across with care packages, ground the mobilisation process to a halt.

Over and above this care at home providers have experienced three increases in the national minimum wage; a low unemployment market place; competition for staff from both inside and outside of the sector; unexpected increases in costs due to the new CQC regulations and the Care Certificate and higher than expected administration costs relating to the seemingly never ending issues providers have experienced with the ECM (CM2000) system, data protection audit and KPI requirements.

4 / How did you respond to packages of care pre June 2014?
Care at home providers would receive a phone call from the brokerage team and would be asked whether they could deliver a care package based on the tariff of prices they had in place at the time.

5 / What issues did you have prior to the framework contract?

Comparatively few, there were and continue to be issues with purchase orders and the timeliness of payments. In the main though, providers had more sustainable services, operated in a market driven environment and experienced far fewer issues with recruitment, training and retention. Carers felt valued, motivated and rewarded and there was a myriad of people who were willing to recommend care at home as a potential career to both their friends and family members.

6 / What are the experiences of discharge processes with care at home packages?

Care at home providers are not able to bid for as many care packages as they would like to due to their inability recruit, train and retain as many carers as they need to in order to run sustainable services. When providers are able to take packages on they can often experience inaccurate contact details, limited to no care planning information and limited to no purchase order information, all of which have the impact of causing providers further problems down the line.

7 / What is the level of staff recruitment and retention and what is being done regarding workforce?

Care at home providers are experiencing unprecedented issues wrt the recruitment and retention of carers, they have tried many innovative methods to recruit and retain carers throughout this period but are limited in terms of what they can do / offer due to the amount they are being paid by for the services they deliver by the Council and the cost of the associated activities.

This has involved newspaper adverts, magazine adverts, radio adverts, working with recruitment agencies, job sites, banners, billboards, bus stop posters, text campaigns, flyer campaigns, demographic profiling, postcode lists, direct mail, open days, job fairs, ex carers letter, carer referral incentives, college presentations, job centres, women’s institutes and rotary club talks.

It has also involved rewards and recognition schemes, enhanced holiday entitlement, help with child care, enhanced pension schemes, long service awards, training and development, stepped pay bands, procurement deals, car lease purchase deals, free DBS checks and uniforms, paid for training and training time, paid for travel time between clients and attractive mileage rates.
8 / How is the voice of the person in receipt of care (and their families) heard?

The voice of the person in receipt of care (and their families) is heard through conversations with care at home carers, these conversations are captured in the client’s care plan as well as in the carer’s supervisions, appraisals and team meetings. Many providers put further mechanisms in place to support these processes including client surveys and discovery interviews.

The voice of the person in receipt of care (and their families) is also heard through Healthwatch, Commissioners, regulatory bodies and other partner organisations both local and national. Care at home providers continually hear that clients are confused about the current arrangements in the county, especially when they relate to invoicing and outstanding moneys.

9 / How do you see the sustainability and modernisation of care at home services?

Care at home providers are finding it harder and harder to address the combined wants and needs of their clients, carers, commissioners and regulatory bodies. If as a county we are serious about addressing this issue, then care at home providers believe that we will have to go through a complete regime change in order to make this happen.

This could be achieved through the prospect of joint commissioning but will be wholly dependent on the associated success criteria and the individuals who are appointed into key roles.

Care at home providers believe that providers should provide care, commissioners should commission care and regulatory bodies should regulate care. Care at home providers also believe that they will really need to be listened to and understood, before working relationships can be rebuilt, sustainable services can be supported and enabled and long term plans can be put into place.

10 / What has been your biggest lesson from this process and / or what would you do differently if going through a similar process?

Care at home providers believe that the biggest lesson they have learnt from this process is that they have a better opportunity to influence outcomes by working together and that if they are going to influence change in a positive way for their clients and their carers, then the only way to do this is through meaningful dialogue with commissioners and regulatory bodies.

11 / How has the communication been between those involved?
The communication between care at home providers has never been better. The communication between providers and some Council Officers remains difficult due to the fact that providers feel down by some key individuals. As a result of this, providers are left feeling disappointed and disillusioned and as a group are finding it harder than they expected to, to trust the individuals concerned. Indeed some providers have highlighted the need for an independent investigation into the situation.

12 / Recognising the difference in scales, is there anything else that could be learnt from national providers or national representative organisations?

Care at home providers felt the need to involve Healthwatch, the UKHCA, Care England, Local Councillors and Local MP’s to help address the issues they have been facing with the Council. Some of these issues have been addressed but the overall situation will never truly be resolved, until a competent project team is put into place, the framework agreement is bought to an end and a level playing field is created, by moving towards a more NHS based style of commissioning.

**Second Submission**

**Health and Social Care Scrutiny Committee - Care at Home Select Committee**

**Submitted on behalf of Lot 1 Provider Representation:**

**Pre Contract**

In preparation for the PQQ and ITT in respect of the current Framework a number of meetings were held by the Council for Providers who were considering tendering. During these meetings the Council presented a number of key suggestions in advance of the PQQ and ITT and it is our belief that many Providers decided to tender based on the information presented in these meetings.

Key suggestions presented by the Council include but are not limited to the following:

Following implementation of the Framework only successful Providers would be offered new work from the Council; the Council indicated that they wished to work with a limited number of Providers and the notion of subcontracting by successful Providers to non-successful Providers was positively encouraged.

**Response to Packages of Care Pre June 2014**

Prior the current contract Providers were mainly contacted by telephone. There was a greater emphasis on ensuring appropriate placement of packages with greater detail of information being provided in relation to the service needs.
Initially, under the current process full post code information was not provided in email correspondence which made it difficult for Providers to appropriately place packages efficiently. Providers repeatedly requested full postal code information from the Support Brokers but were advised that this was not possible. After many requests, the full post code information was eventually provided making the potential allocation of work easier. Under the current process, where bid details are provided by email, detail around package needs are sparse and in some cases inaccurate. Providers have advised that when full support plans arrive after winning a bid they contain additional and important information that should have been provided with the initial details. The additional information in some cases will mean having to deliver a different type of support than anticipated at the point of bidding.

As discussed, there were issues with Purchase Order Provision prior to contract but these issues had been occurring for many years despite Providers raising concerns with the Council on many occasions.

**Recruitment:**

A concern amongst Providers who intended tendering for a position on the Framework was that their ability to bid for work would be dependent on their ability to recruit. The Council indicated that throughout the 6 month mobilisation period Service Users would be moved from Non Framework Providers to Framework Providers and it was suggested that this would encourage staff mobilisation because volumes of work would shift from the many to the few. The Council discussed at some length the need to be aware of TUPE issues and tried to encourage the sharing of staff information in this respect and it was suggested that the Council’s intention was to enable successful Providers to grow their businesses.

The general assumption by both Providers and the Council was that because of the reduced number of Providers the Council was going to work with, successful Providers would attract the necessary staff to provide the additional volume of services needed and many Providers submitted Tender Prices based on their ability to uplift in numbers of hours delivered in order to counter the reduction in charges.

Most Framework Providers have reported having lost staff as a result of being a part of the Framework with reports of halving in size at worst with some remaining static and one smaller Provider reporting that they had increased in size.

Providers have been advised by the Council that National Providers have no interest in delivering services in Cornwall. Cornwall is unique in respect of its geography (not surrounded by numerous other Counties therefore difficult to draw in staffing from neighbouring Counties) and its mix of rural and urban locations makes it more difficult to provide a one size fits all model of provision.

Reports from some Providers have suggested that recruitment and retention was effected at the start of the contract (and continues to do so) as a result of the introduction of Electronic Call Monitoring (ECM). As discussed, Non-Framework Providers are not subject to ECM and some Framework Providers have advised...
that they have either lost existing staff to Non-Framework Providers or when new staff apply one of the first questions they ask is "do you use Electronic Call Monitoring" some applicants have withdrawn from the process once this has been established.

Processes around recruitment are also hampered as DBS applications can be held by the Local Police Force for up to 60 days before anything can be done to progress these applications.

This means that up to three months after initially offering a position and putting an applicant through training and shadowing can pass before they allowed to work solo.

There appears no rhyme or reason as to why some applications are held up whilst others go through quite quickly, however, in the main it appears to be down Local Police Force’s resource issues – they simply do not have the time or personnel to sift through the process quickly.

Because of this, some Providers have reported that applicants have withdrawn from the application process due to the wait involved. It is a great pity that such an administration issue can result in loss of staff to this industry as just one additional applicant added to a pool of staff could potentially mean the ability to support 6-8 new Service Users.

**Charge Rates:**

The current rate of £16.00ph is not sufficient for Providers to pay rates in line with a living wage. This is one issue facing existing Providers as they are unable to compete with the likes of supermarkets and other non-care related business that can support wages higher in line with a living wage. Front line staff working in the domiciliary Care Sector face many challenges throughout their working day including early starts, travelling between clients and late finishes. There is a feeling that the role of Care Worker is not recognised for the skilled role that it entails and until both local and central government are able to fund appropriate charges it will not be possible to pay a sufficient and deserved wage equal to a living wage or higher.

Reduced rates were encouraged by the Council throughout the lead up to the Tender and their inclusion of a guide rate of £14.50 per hour for Care Services and £12.00 for Domestic Services confirmed their intention to drive charges down.

Indeed, prior to the Contract questions were submitted to the Council relating to the Council’s guide rate Clarification log as follows:

Clarification log number 009 asked the following question:

"Using the UKHCA guidelines of 11.4 minutes travel time and 4 miles between service users and assuming the majority of calls are 30 minutes. If a company carried out all the indicative hours for Lizard and Helston of 1902 hours paying current minimum wage of £6.31, the annual employment costs would be £1,399,946. The income from CC based on the guide price of £14.50/hour would
be £1,434,108 leaving £34,162 for rent, utilities, admin, supervision etc. It is clearly not possible to provide high quality care on that basis.

Please clarify how the guide price was derived and confirm that it includes provision to ensure that providers meet their obligations under minimum wage legislation.”

The response provided by the Council was:

"The guide price has been modelled by the Council’s finance team and agreed by the Adult Care Health and Wellbeing directorate as being appropriate to meet all statutory requirements in respect of the National Minimum Wage. However Bidders are reminded that the guide price is simply that, a guide price. Therefore Bidders are free to respond to this opportunity according to their own business policies.”

Additional questions were asked as follows:

"a) Is it legal (Care Bill Act in Parliament) moral or ethical for the Council to seek to procure services at a target price of £14.50 when accepted evidence from the UKHCA states that the minimum rate for providers only paying the current Minimum Wage is £15.19, not taking into account the Low Pay Commission’s recommendation of a 3% increase to £6.50?

b) Can the Council recommend how, with the target rate of £14.50, service providers can provide a quality service and recruit and retain staff without paying in excess of the National Minimum Wage and moving towards paying the Living Wage. The Council’s strategy appears to be forcing Service Providers to pay low wages which does not assist in its Sustainable Communities Strategy”

During the recent costing exercise carried out by the Council Providers asked for the 'modelling' as indicated in the Council's response above to be provided so that it could be included in the discussions but this request was denied.

In addition, a report produced by one the Council’s own Finance Officers was produced after visiting and speak with a number of Providers in March 2015. The purpose of the visits was to gather evidence from Providers relating to their current financial positions as a result of Framework inclusion and Providers involved were advised that the report was to be submitted for use during the costing exercise. Providers were advised by that Officer that the report had been submitted to the Council but when Providers requested sight of this the Council denied its existence.

At this stage we would ask once again for the Council to produce the information relating to the modelling carried out prior to Tender given that subsequently it has been acknowledged that the suggested guide rate is simply not sustainable, as well as the report produced prior to the costing exercise which subsequently led to the uplift to £16.00 ph.

A number of Providers have advised they applied due diligence in terms of developing economies of scale models in line with suggested future availability of work provided by the Council.
Data Inaccuracy and Misleading Information around Procedural Matters:

Data provided by the Council relating to the number of hours available within the geographical zones was out of date and subsequently found to be an inaccurate summary of the actual hours available. This was confirmed by one of the Council’s Finance Officers who visited some Providers prior to the costing exercise.

Many providers were unable to achieve the economies of scale necessary to achieve a sustainable financial model due to the lack of movement of staff within the Market Place, which many Providers believe was as a direct result of the Council continuing to pay (from the beginning of the Framework Agreement) Non Successful Providers at their old rates of pay (i.e. a mainly higher rates than successful providers – later confirmed by the Council to be on average £16.50ph).

This matter was compounded by the fact that the Council began commissioning new work from Non Framework Providers within six months of the contract, who were not under the same restrictions as Framework Providers, could charge higher rates, did not have to use Electronic Call Monitoring or deal with its associated administratively heavy processes and were not obliged to meet KPI requirements of successful Framework Providers. At month 17 into the Contract, the Council continues to work with Non Framework Providers who do not have any of the above mentioned restrictions and, as has been confirmed by the Council charge on average £16.50 per hour for services, which is 50pence higher than even the recently uplifted rate of £16.00 for Framework Providers.

A further compounding issue was that Framework Providers were expected to reduce their charges to the new contracted rates less than one week after signing the contract in June 2014 whilst Non-Framework Providers continued to charge their existing rates.

Many Framework Providers have indicated that this came as a surprise as they had expected their new ‘charge rate’ to begin following the six month mobilisation period. Given that Non Framework Providers were able to continue providing services throughout the first six months of the contract (and some continue to do so) at their existing rates (£16.28) whilst Framework Providers had their rate cut immediately, it is felt that this directly impacted on movement of staff within the market place. Whilst Framework Providers ran into a steady decline Non Framework Providers continued to thrive with some reports from Non Framework Providers advising that the introduction of a Framework was the best thing that had happened to them as they had not had their services taken away from them as advised by the Council prior to the contract but had continued to provide services and had managed to retain their existing rates.

Experience of Discharge Processes:

In respect of procedures around discharge Providers have indicated that often when they are advised that a Service User is to be discharged and a date of
commencement/recommencement of service is agreed Staff will arrive at the Service User’s home at the agreed time to discover they had not been discharged.

The Provider had not been contacted to advise of any delay and often this occurs out of hours adding further complexity to the process.

**Sub-contracting:**

A number of Framework Providers attempted to engage with Non-Framework Providers prior to and during the early stages of the contract. However, because charge rates for many Framework Providers had dropped significantly as a result of the joining the Framework, and therefore any agreed sub contracted rates would need to be lower, the general response from Non-Framework Providers was that they would hold off on any decision to sub contract until the Council began reassessing their own clients. The rationale being, why would Non-Framework Providers agree to sub-contract at lower rates when they were still continuing to work with the Council at their existing rates which were higher?

**Electronic Call Monitoring and Billing using CM2000:**

Prior to Contract Providers were led to believe by Council Officers that Electronic Call Monitoring (ECM), had been fully piloted but concerns were raised by a number of Providers involved with the Piloting who explained that the financial model of this process had never been completed during the Pilot. This resulted in Framework Providers being subjected to the use of a partially functioning and administratively heavy billing system and despite very many promises from Project leaders within the Council of the implementation of full finance manager system the system Framework Providers are working with is still only partially functioning at month 17 into the contract. Indeed there is a feeling that current Framework Providers are acting as a Pilot for this system and had they been made aware of this prior to contract this may have had an impact on their decision to Tender.

Electronic Call Monitoring (ECM) was introduced in August 2014 and the introduction of minute by minute billing in October 2014.

Council Officers have maintained that the primary purpose for introducing ECM was to monitor quality and to ensure missed visits were captured. Many Providers have indicated that they are fully supportive of the use of ECM for these purposes and believe that some form of monitoring is a useful process. However, the use of CM2000 and ECM for billing has caused problems for Providers and the Council since its inception in October 2014 and at month 17 into the Contract the process is still not accurate.

At the time of its introduction it was clear that the Council were unable to ensure payments to Providers under the minute by minute billing structure as it was not fully operational. This resulted in the introduction of an interim billing period, which hugely disadvantaged Providers in terms of administrative duties and was inequitable across the delivery of services, as it was known that not all Providers were billing the Council under the requested process but were still being paid for the services they delivered on a planned visit basis.
The Council indicated 3 times throughout the initial introductory period that unless Providers submitted invoices based on actual delivered services, as opposed to planned visits, they would not be paid and eventually this led to ‘bonus’ payments based on percentage delivery being made to those providers who had managed to make the partially functioning systems work.

This resulted in further inequitably as the way in which these bonus payments were calculated did not appear to take into account the number of Client Contributions each Provider had to process nor the weighting of multi-rate vs single rate clients which caused a great deal if additional administration. In addition, those Providers who were not able to bill as requested were still faced with the same difficulties around billing which took many months to resolve and it is felt that this could have been avoided had the Council Officers listened to Providers at the time of the billing introduction instead of ploughing ahead with such an inadequate and untested process. In essence, the provision of a bonus payment was viewed as process by which the Council could justify such a poorly implemented process. It did not help those Providers who were struggling to implement the system and given the system was flawed, untested, and partially function this compounded the efforts of Providers to get the system to work for them.

No information relating to the process of ‘interim billing’ was presented by the Council as part of Tender Process, nor was it indicated by the Council prior to Tendering, it is believed that no Provider could have factored in the additional costs relating to the introduction of interim billing by the Council and on this basis it is suggested that interim billing and all that it entails should not have been introduced in the manner it was. This is confirmed by the fact that the full system has still not been introduced over a year and a half into the contract. In sum, the Council has struggled for at least 16 months to get its billing system to work, it did not fully test the system prior to the contract beginning and because of this it is felt that Providers were misled prior to the contract over the requirements of ECM and the use of CM2000 system.

**Purchase Order Provision:**

Prior to the Framework concerns were also raised with regard to the Council’s inability to provide Purchase Orders on time and containing accurate information – this has always been an issue and for years prior to the current Framework Providers have brought PO provision to the attention of Council Officers.

The Council Officers involved in meetings prior to the current Framework indicated that this was something they were aware of and would have to ensure that appropriate processes were in place to deal with such issues when the Framework began.

As we enter month 17 of the contract the issue of timely and accurate Purchase Order provision has yet to be resolved resulting in much additional work for Providers from both a delivery and payment point of view.

The Council was made aware again of issues around non receipt of Purchase Orders at the time of Commissioning from the start of the Contract. However,
despite being asked about this on very many occasions and despite being promised a responses there was no change.

Providers were advised in early 2015 that a ‘legal’ problem relating to Purchase Order Provision had been identified which meant that these could not be emailed to Providers.

Notwithstanding the fact that Providers were led to believe PO provision issues would be resolved prior to contract, emailing of POs was eventually introduced by the Council approximately six months later and there was a suggestion by some Officers that this had now resolved the issue. However, this has still not addressed the provision of timely and accurate provision of these orders as timely provision is dependent on assessment and re-assessment information being entered onto the Council’s own systems then disseminated to Providers at the point of entry. This still does not happen and Providers are still faced with additional administration as a result of the Council not having resolved this issue.

Invoices are returned unpaid advising that because assessments have taken place resulting in new Purchase Orders being raised containing changes to charges the invoices are incorrect. The invoices are incorrect because the new information was not provided to the Providers quickly enough for them to update their own systems with some new information still only arriving 4 – 6 weeks after the changes had occurred.

Information relating to the introduction of Client Contributions following the Council’s financial assessment of Service Users does not reach Providers in time for them to include this information on invoices, which consequently results in numerous invoice returns for amendment resulting further in delays in payment. And, often Service Users appear to have been assessed incorrectly and this results in further delays in payment to Providers whilst discrepancies are investigated.

Services Users appear confused and concerned at receiving invoices and will say that they simply do not understand the process of client contributions. Unfortunately, explanation of such issues falls to the Providers as the Council’s default response is that the Service Users are provided with all the necessary paper work at the time of assessment.

**Mistrust of Council Officers:**

Within the first six to nine months of the contract the Council did not acknowledge the disparity across the Market in terms of how work was being commissioned and did not appear to recognise the impact that this inequitable process was having on successful Providers. Many Providers tried to inform Council Officers within the first six months of the contract that they were experiencing problems and whilst Officers would meet with Providers to discuss such issues many were told that they were the only Provider who had raised these matters. However, it soon became apparent that this was the default response from Council Officers as many Providers had become aware that they were being told the same thing.
This led to Provider suspicion of Council Officers and a feeling that when concerns were raised these concerns would either be completely ignored or lip service would be paid with no resultant resolution being provided.

Because of this, Providers contacted Cllr Jim McKenna to discuss their concerns in early January which subsequently led to the formation of a Framework Representative Group being formed in an attempt to address the numerous concerns Providers felt were not being appropriately responded to by Council Officers.

**CORMAC AND CorCare – Council Spine Provider:**

Existing Providers have been advised by the Council that to address the issue of capacity CORMAC’s Cor Care has been created in an attempt to cover shortfall within the sector however, there is a feeling amongst existing Providers that an inequitable process has been supported by the Council.

When Providers became aware, through media coverage of this service, that a living wage was to be a starting point for those working within the service this caused considerable concern amongst existing Providers as it was felt that in order to support such a wage, costs to the Council for such a service would inevitably exceed the recently authorised uplift figure of £16.00.

Providers have tried to establish whether the charges they have been capped at are equal to or at least close to those agreed with CORMAC but neither CORMAC nor the Council have been willing to discuss this.

Existing Providers have previously been advised by numerous Council Officers and Cabinet members that CORMAC’s COR Care domiciliary and STEPS service has simply been formed to pick up cases in the event that existing Providers (both Framework and Non Framework) are unable to service.

However, this position seems contrary to information presented [here](http://www.cormacltd.co.uk/latest-news/2015/october-2015/new-care-services-for-cormac/)

in which it states “The new home care agency will initially run as a pilot project and will be up and running to offer support services to people who wish to use their personal budget or private payers from April 2016.”

To clarify, Providers fully support any quality service that will be in a position to assist with capacity issues across the County and fully recognise the Council’s need to take action to address such issues.

Providers have been advised that COR Care is treated as an external provider in the market and Cornwall Council are holding them to account through robust contract monitoring and performance management processes as with other providers in the sector. However, whilst, COR Care may be subject to the same requirements in terms of monitoring and performance management existing Providers have questioned whether Cor Care is expected to deliver these same
services at the same hourly rate of £16.00ph at which current Providers are expected to deliver and develop their services.

A higher hourly rate would clearly enable any business to develop their services at a more rapid rate and whilst CORMAC has initially indicated that they are in the market simply to cover current unmet demand their literature suggests that this is not the ultimate aim.

Indeed, Simon Deacon Director of Operations for CORMAC has said the following about their new service: "This wasn’t something that was on our horizon and we did not have plans to enter the care sector, but we are happy to use our commercial and service driven ethos to help the Council find a solution to fill some of the gaps and help individuals receive the care they need. In the long term we are hoping to further develop the service in a way that we have done with other areas of business.

To clarify matters with current Providers it has been requested that a meeting be held between the lead commissioner and Providers, which would allow CORMAC the opportunity to allay any concerns existing Providers may have in respect of its current and future services and hopefully enable an ongoing positive and solution focussed dialogue with the aim of addressing issues of capacity across the County. Unfortunately, this suggestion has not been taken up by the lead commissioner.

Ultimately, it is felt that the Framework Agreement no longer appears fit for purpose based on the current market and as we move towards joint commissioning decisions to continue with such onerous and partially functioning systems required under the current contract seems nonsensical.

KCCG has made no clear commitment to the future use of ECM or the use of CM2000 ECM for billing and as KCCG work with many more domiciliary Providers than the current 23 involved with the Framework it is not clear whether continued use of the system for all would either be practical or cost efficient. And the fact that over half way through the current Framework contract issues around ECM and billing have still to be resolved it begs the question as to why KCCG would want to pursue a system that is not fully functioning and only serves to cause many Providers increased administration.

It is clear that the ability to recruit is having a serious impact on the Sector as a whole and this is unlikely to resolve quickly in what has turned into an inequitable Market where ‘Successful’ Framework Providers are working hard to meet the many requirements and restrictions of a Framework Agreement whilst non Framework Providers continue to supply the Council with Services without such restrictions and responsibilities.

In addition, existing Providers fear that they will soon be in competition with the Council’s Spine Provider who appears to sit outside of the process in terms of a restricted charge rate of £16.00ph and as such could potentially build their service at a more rapid rate than existing providers.

A number of Providers have advised that if it were not for injections of personal cash or for the ability to use monies from additional services (i.e. Care Homes)
to prop up their domiciliary care provision they would have had to close their
doors within the first 6 to 9 months of the contract. Despite such matters being
brought to the attention of Senior Officers within the Council it was not until the
intervention of Cllr Jim McKenna that these issues were taken seriously and if it
were not for his intervention and subsequent application to Cabinet for an uplift
in charges some businesses would no longer be here today. The ramifications a
number of mid to large organisations being left in the position of no longer being
able to provide care for such reasons are that lack of capacity could increase to
in excess of 3000 to 5000 hours per week within a very short period of time.

In sum, it is felt that the current Framework Agreement is no longer tenable due
to the fact that the landscape has so demonstrably changed since June 2014 and
the agreement only serves to hamper efforts to deliver Care Services within the
County of Cornwall. The Framework in its current form has not resolved capacity
issues despite the best efforts of all Providers involved (whether Framework or
Non-Framework) and it is felt that the unwieldy nature and overly
administrative complexity of the Contract has obstructed the process of Care
delivery by placing additional, unnecessary and untested, burdens on Providers
who struggle daily to meet the demands of delivering a quality service in a
grossly underfunded industry.

**Lot 1 Provider Representation**
Written Evidence Submission from Cornwall Partners in Care

A lot of the questions contained within the key purpose and scope of the Care at Home inquiry are directed at me as a single framework provider but, as Chairman of CPIC, I have arranged for the answers to be representative of the sector as a whole.

1/ Will the steps in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?

- The uplift was a good idea in principle, but was not sufficient to make things work. It is a “sticking plaster” which will not address the additional costs associated with the introduction of the living wage in April. Although the UKHCA costing model was used in the costing exercise and CPIC were instrumental in bringing the relevant parties together, the Council adapted the model to establish a rate of £16.00. Had the Council used the specific model a higher rate would have been achieved.

- The spine provider will not solve the capacity issues and should not have been necessary had existing providers been paid at a rate which would allow recruitment and retention of staff. The spine provider, having more generous terms and conditions, could make the situation worse by drawing staff away from existing providers and could become more than a “safety net” provider if the current “uneven playing field” is not addressed.

- The Direct Payment rate has not been uplifted and remains at £14.50 until cases are re-assessed which could take up to a year, and many providers are working in the dark as to when these assessments are due.

2/ How do you think the system will cope with winter pressures?

- Providers need to be paid at rates which enable them to recruit, train and retain staff.

- CPIC Committee members have been engaging with the Council and NHS Kernow to look at how the sector can assist in reducing bed blocking, and we are happy to continue with this engagement - although it needs to happen in a more coordinated way. Some other issues need to be considered - such as the payment of retainers to providers so that Service Users do not have to be “re-brokered” when they are admitted to hospital. Providers assessing the timings of their own packages - rather than waiting for Council staff to undertake a full review - could also release some capacity into the system.
3/ You bid at a rate which you had established, what has subsequently changed in order for the system not to work effectively?

- Bids were based on the Council guide price of £14.50 which was set too low, and we have been given no evidence as to how this guide price was set, and so we have no indication if due diligence was undertaken. Many providers chose not to bid because they realized that the contract would be unsustainable.

- Since the introduction of the framework agreement, the whole marketplace has changed beyond recognition as a direct result of the following factors:

1. Care Act
2. Care Certificate
3. CQC – higher level requirements
4. Pensions
5. Minimum/Living wage
6. CHAS
7. Data Control requirements
8. Administrative burdens such as CM2000 and KPIs
9. High employment
10. New higher wages paid eg by Lidl and Aldi
11. Sub-contracting arrangements proving to be unworkable.

4/ How did you respond to packages of care pre June 2014?

- Spot purchasing - whereby over 100 Approved Providers put in bids which reflected market rates and the true cost of care. There was a healthy competitive market which involved all providers of care who were on the Approved list.

- NHS Kernow are still using spot purchasing arrangements.

5/ What issues did you have prior to the framework contract?

- There was a healthy diverse market prior to 2007, but from 2008/09 there was a process of destabilization due to a downward pressure on pricing, which conflicted with increased costs due to Working Time Directives, the minimum wage and increases to National Insurance.

- Spot Purchasing was more flexible, and allowed the above factors to be taken into account and, where necessary, higher rates could be paid to staff to recruit, train and retain staff, as care workers were beginning to exit the sector.

6/ What are the experiences of discharge processes with care at home packages?
• There is little communication/interface between hospitals and Care at Home providers, and discharge planning needs to be improved and “bridges built”.

• 7 day per week brokerage would assist with capacity issues.

• The list of Council packages awaiting placement with providers is not always updated in a timely fashion.

7/ What is the level of staff retention and recruitment, and what is being done regarding workforce?

• The fundamental issue of recruitment and retention in the Health and Social Care sector has been made worse through the introduction of the framework agreement.

• In times of full employment the problem becomes more acute, and because of Tax Credits a large percentage of the workforce will only work part time, requiring more personnel to cover the same hours.

• New living wage uplifts will improve staff terms and conditions but they will still see themselves on the “minimum”, and therefore we will have to pay substantially more than this “minimum” because people can get the same money in jobs which have far less responsibility, and are more flexible and family friendly.

• These problems are not helped by the low profile of the sector - which is not helped by the “blame culture” directed at providers and associated negative media attention.

• Job Centre Plus have provided evidence to demonstrate that job seekers are unwilling to take up posts within the health and social care sector because of low pay and unsociable working hours.

8/ How is the voice of the person in receipt of care (and their families) heard?

• Our staff speak to them every day and feedback is encouraged so that Team Leaders and Managers are aware of any issues.

• Families and interested parties are involved in the assessment process.

• Quality Assurance questionnaires and Health Watch ensure that the voice of the Service User is heard.

9/ How do you see the sustainability and modernization of care at home services?

Health and Social Care Scrutiny Committee – Select Committee Review of Care At Home December 2015
• Since the introduction of the framework agreement the sector seems to have gone backwards.

• The sector has been put through a process which was both costly, onerous and extremely stressful. It should be recognized that the capacity issues currently facing the sector could have been far worse had providers of all types not used personal reserves to keep them sustainable until the uplift was received.

• Commissioners of care do not seem to understand the pressures facing providers.

• Providers need to be treated as equal partners through meaningful dialogue and true engagement.

• National evidence from the Kings Fund regarding demographic and cost pressures facing the sector do not seem to have been taken into account.

10/ What is your biggest lesson from this process and/or what would you do differently if going through a similar one in the future?

• The first tender was challenged and acknowledged as being flawed. The evaluation process was compromised – “scoring” was the area of the challenge which was successful. If it were not for this failure, we would not be where we are today, and significant costs would not have been incurred by the Council and individual care providers.

• The tender fragmented the market, and a “divide and rule” philosophy has damaged relationships

• The second contract was put together in a legalistic way with significant input from solicitors and accountants with no due diligence to ensure that the measures contained within the contract were practical

• Linked to the above point, sub-contracting arrangements have proved to be unworkable, despite attempts to make the arrangements work.

• There have been huge administrative burdens placed on providers due to the cumbersome nature of the contract. For example, Key Performance Indicators which have not been equally applied to all providers

• Despite initial consultation with providers on the introduction of Electronic Care Monitoring, the pilot scheme was halted with no proper evaluation and agreement on matters such as minute by minute invoicing.
Health not being part of the tender was a major shortcoming as it has enabled some non framework providers to thrive. It was always assumed by the Council that staff would move from non-framework to framework providers although this never happened in practice. The Council were not conversant with TUPE requirements as they assumed it would be relevant to Lot 1 providers which was not the case. All providers were asked to submit TUPE information which further destabilized the market. The size of the contract was over estimated as Health data was included.

There appears to have been insufficient expertise within the Council to introduce the framework agreement. A lack of leadership, provider engagement, and project management has hampered the process.

A lack of accountability has meant that problems have not been addressed in a timely manner.

A report prepared by [REDACTED] from the Councils’ Audit Department reviewing some of the shortcomings of the framework agreement was never shared with providers.

11/ How has the communication been between those involved?

There was no opportunity for providers to have a say in what would or would not work - even after the failure of the first contract when there was a request for dialogue which was ignored. During the two tender processes there was a complete block on provider engagement which lasted for 18 months.

There seemed to be a lack of accountability with a perceived reluctance to engage with the sector at the start of the contract when problems became apparent, and this continued until Councillor McKenna as the Portfolio holder agreed to get involved.

Communication with non framework providers was only initiated when capacity issues and “black alerts” were apparent.

The tone and approach of council communication has appeared to be defensive and patronizing with no vision, plan or solution when providers presented problems. This lack of real and meaningful engagement has undermined Council credibility and working relationships, and is a key issue which needs to be addressed if the sector is to move forward in a positive way.

12/ Recognising the differences in scales, is there anything that could be learnt from national providers or national representative organizations?
• From the onset of the tender process, providers were in touch with UKHCA and Care England – the problem was that the Council would not acknowledge this input.

• The recent pricing uplift was based on a UKHCA costing model and CPIC were instrumental in bringing the relevant parties together.

• The current UKHCA costing tool specifies rates which flex according to new cost pressures such as the living wage, new pension requirements etc, and needs to be acknowledged by the Council as a tool by which the true cost of care can be recognized.

DLS
25/11/15
Written Evidence Submission from LOT 2 Providers

Lot 2:
We provide 24/7 care in line with Cornwall Councils key commissioning strategies which are aimed at improving individual and strategic outcomes and supporting people to live in their own homes for as long as they wish to.

We achieve this by delivering high quality services that are flexible and responsive and give people choice and control over how their care and support is provided.

Whilst we are here today representing the Lot 2 Sector our own individual organisations deliver in excess of 14,000+ hours per week (United Response 6,000+ hours – Brandon Trust 8,000+ hours)

Processes Undertaken:

Framework for Care at Home - Implementation 1st July 2013.
The first process undertaken in 2013 was based on ‘Quality’ and as long as providers met the quality standards they would retain their existing business. Providers quoted the rates that they were prepared to bid for any new business that was offered through the Framework.
The Guide Rate was quoted as £15.00 per hour.
Whilst we recognise that the failure of this process had a financial impact on the Council we would like to remind all concerned that there were also costs incurred by all contributing Providers. The costs to United Response were in the region of £54,000. This was similar to the costs for Brandon trust resulting in an overall cost in the region of around £100,000+ for both organisations.

Framework for Care at Home - Implementation June 2014.
The second process held an element of quality but was heavily weighted as cost competitive. Providers were now disadvantaged, as through the first process the Council had the previously disclosed hourly rates that organisations were prepared to bid for new work.
The Guide Rate was quoted as £14.50 per hour.
Our businesses were now at greater risk with the second process as it was very evident that there was a general theme of reducing providers and moving to sub-contracting and no agreement to retention of existing business leading to the potential risk of losing ALL of their provision in the County. Throughout the Tender process a recurring theme was that there was to be a drastic reduction of Providers across Cornwall, with unsuccessful Providers potentially sub-contracting to Framework Providers. Provider bids were based on economies of scale due to major growth.
The above factors led providers to come forward with their best possible price. Both tenders were predicated on growth.

Expectations of Growth for Successful Providers.
Framework Providers were called upon to present their Business Implementation Plan at a face to face meeting at the Council. United Response implemented a structure which cost £84,000 in order to position themselves for rapid growth. This was welcomed and complimented by Council officials, who expressed their gratitude that we had positioned ourselves so well. At no point was it stated that this was excessive or that there would not be a mass mobilisation.
At a United Response meeting in August 2014 with family members a senior commissioner advised that there were 183 people in receipt of support in Lot 2 who’s provider had been unsuccessful in the tender process and that there had been a significant increase in the number of Direct Payments across the County. There in reality, was very little growth in business across the county.

**Savings Given to the Council**
In 2008 the average rate for Care was £22.00 per hour (allowing us to facilitate expensive TUPE transfer staff from NHS). The cost of contractual change for Brandon trust in order to support a sustainable workforce was £1million pound which was found from organisation reserves.
In 2013 this reduced to £15.69, followed by our Framework rates being applied in June 2014.
For United Response based on an average of 6,000 hours delivery this equates to Savings to the Council of just under £2.5 million. For Brandon Trust this figure is in the region of £3 million giving a combined total of £5.5 million.
With each rate reduction this has meant extremely costly re-structuring and hence redundancy payment costs etc. which further extends our losses.

**The inequitable treatment of providers in Cornwall leading to some, like UR and Brandon being put at severe commercial disadvantage.**
For the Councils ‘Successful’ Framework Providers their new reduced rates were implemented with immediate effect in June 2014. For United Response this meant a reduction of £425,000 from their budgets and for Brandon Trust this was an even higher figure of £650,000.
For ‘non-successful’ providers they were allowed to continue on their previous rates for a further 6 months+ and were then almost 100% supported to move across to the Direct Payment rate of £14.50 which has now been increased to £16.00 with the recent uplift that has been afforded to Lot 1 and those with Direct Payments. This has very clearly skewed the recruitment market place and forced us to up lift our rates of pay in order to attract staff. This has meant a substantial investment from reserves for both organisations. This cost is year on year.
There was a very clear timeframe and Mobilisation Plan to support families of ‘non-successful’ providers to move to Direct Payments. This was achieved within the first 6-9 months of the new Framework.
There has been no Mobilisation Plan to support the families of the ‘Successful’ Framework Providers to be moved across to Direct Payments, which has the added benefit of providing ‘peace of mind’ for families and people supported from potentially losing their provider at the next Tender process.

**Conclusion**
We understand the climate we are currently working in is extremely financially challenging and we are not asking for ‘preferential treatment’ – just equality.
We have been involved in on-going negotiations and discussions within Jim McKenna’s Meetings with Care Provider Group for almost 12 months and completely understand the pressures on Lot 1 with bed blocking at the Royal Cornwall Hospital, but the question is now about sustainability.
We have been committed to Cornwall and continue to enjoy an excellent relationship with commissioners but our organisations have been commercially disadvantaged by our success on the Framework and both
our organisations are now having to supplement our income from our organisations reserves.
The financial situation is now critical, to the point where serious consideration is being given by each organisation with regards the ability to continue to operate in Cornwall.
Written Evidence Submission from Non Framework Providers

Submission by Mary Anson – non framework provider.
Responses compiled from both personal experience and from information given during various consultations with other non-framework providers.
Prepared November 2015

1. Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?

Unlikely now the new NLW has been announced. This has been set at a very high level. Traditionally care providers (in Cornwall) have always strived to pay above the NMW in order to try to attract staff into the sector and away from other, less challenging jobs such as retail, supermarkets, tourism, etc. I really doubt we will be funded well enough to continue to have this ‘edge’ on other local employment sectors which, if we can only match, rather than better, the pay rates in supermarkets (for example) will make the situation for care even worse, not better, despite the welcome increase in the new minimum (the Living) wage, which is on its way. Our carers will now be bumping along the new, albeit higher ‘bottom’ instead of just above it, as now. The spine provider is advertising and competing for staff at higher rates of pay and attracting staff away from ourselves.

2. How do you think the system will cope with winter pressures?

Without a significant tranch of new care staff coming into the sector, we will not be able to make much if any impact on the winter pressures; it will not be helpful either, if the domiciliary care market improves pay so that it draws carers away from the residential care sector, as this will only move the problem around- and vice versa.

3. You bid at a rate which you had established, what has subsequently changed in order for the system to not work effectively?

There are different types of non-framework provider, and who are generally in different positions now:
1. Those who were never interested in tendering at all and did not attempt PQQ – so did not bid at any rate
2. Those who failed at PQQ so were not eligible to tender (and were not allowed to see the tender details) so could not bid at all
3. Those who passed PQQ but decided the terms of the tender requirements were not something they felt they could work with so did not continue on to submit a tender – they did not bid at any rate
4. Passed PQQ but failed at the tender (ITT) stage – these did put in a bid, but failed to get through for varying reasons, not necessarily related to the bid rate.

As a care provider who failed, on very spurious and ill-informed judgements, to even get as far as the tender (as at Point 2 above), I was one who was therefore not in a position to tender at all. So nothing has changed (as per
your question) for me. My failure to qualify at PQQ was because the process indicated that my financial gearing was wrong and therefore my dom care service was not viable, something that is patently not true (bank letters of support were subsequently offered). The process failed to take into account that my ‘gearing’ included capital debt for four residential care homes. This was particularly inept of the people who wrote, approved and evaluated the tender document. My dom care service is not a stand-alone limited company, so the accounts as requested involved my whole service. This was not understood by council.

However, there have in any event been many changes which have affected all agencies since the tender process began. These are:

The Care Act; Auto-enrolment of pensions; implementation of the National Living Wage; tax credits. Certain supermarkets, and STEPS (now Cor Care) were (and still are) paying considerably more than is possible for many of the rest of us. In times of labour shortage, the ability to reward staff is crucial.

4. How did you respond to packages of care pre June 2014?

Speaking from a personal perspective only, I (and at least one other that I am aware of) were held back from taking council funded work due to the council’s own bureaucratic processes which, although registered with CQC, could not enter onto the former ‘preferred provider’ list. Consequently these agencies had to wait – for years in some cases – with a service the council’s conditions meant it was not allowed to use. Your loss!! The agencies thrived without council funded work.

Several agencies set up in Cornwall having achieved CQC registration since the start of the last ‘preferred provider’ list several years ago. The council excluded itself from using these agencies by its own bureaucratic processes, by excluding new entrants into the market. These agencies established their own market position, operating successfully with heath- and privately-funded clients. Some of these saw no reason to tender for council funded work when the opportunity to apply (the tender) took place; others, at not inconsiderable expense, passed the first tender process, both at PQQ and at ITT, only to have this disregarded when the council’s own flawed process resulted in the first tender being abandoned after a legal challenged.

This resulted in considerable disillusionment with the council as a ‘partner’ it was safe to do business with, let alone tie themselves into any sort of onerous contract with. The second tender was badly designed, as it ruled out some agencies at PQQ stage for spurious reasons where the council literally failed to understand ‘gearing’ (as in my own case), ruling my service as financially non-viable – the council had set criteria which were unable to take into account the accounts where another service (a care home with a totally different capital debt structure) required a significantly different financial structure to that of a stand-alone domiciliary care agency. Another (not for profit) provider failed at the same point by missing a deadline by 24 hours, having omitted in error to supply a copy of the insurance certificate – again, at a considerable loss of potential capacity to the council.

Non-framework providers now tender for work at what is a viable rate for them, and are only restricted in capacity due to the availability of staff. Many of these agencies now pay their staff considerably more than agencies
on the framework. Non-framework providers are generally able to operate at rates and conditions which are better, and therefore more viable, than those who were successful at getting onto the framework. Surely, a state of affairs which the council has brought on itself, but which is divisive within the sector itself and which risks the loss of framework providers who are considering exiting the market, leaving a situation where non-framework providers could be the more likely to survive than the ‘successful’, framework, providers.

5. What issues did you have prior to the framework contract?

An inability to make my viable service available to the council; hence I did not recruit staff in sufficient numbers which would allow us to take on council funded work at a time when recruitment was actually easier than it is today. We only carried out work for health- and self-funded clients, usually end of life care or other short term packages. As it is, our service continues to run well without having to depend on the council, but our staffing levels restrict our ability to take on much current council funded work.

In actual fact, the sector worked reasonably well until somewhere around 2008/09 when the council employed an officer (called [redacted] I believe) whose activities in preparing the ground in order to implement a tender process began to pull the sector apart. While she did not stay for long, it was long enough to commence the unravelling of the sector into the capacity crisis the council is experiencing now.

6. What are the experiences of discharge processes with care at home packages?

Common to all services - framework, non-framework, and care homes too - are some major problems which occur all too frequently, and which put service users at risk, thanks to frequent inaccurate or lack of information being supplied by the various NHS and social care personnel. This is presumably due to the pressures to get someone out of hospital regardless, it seems, for what might happen to them after an ill-informed and inaccurate handover to the provider who is often left without the right information which would allow them to provide safe care. This has led to a lack of trust by agencies and care homes alike. These errors include, but are by no means exclusive: failure to notify providers about a relevant medical condition; failure to inform about the need for pressure relieving equipment; late transport for discharges; generally poor communication; inaccurate or no medication coming out with the client; no discharge summary; to list just a few.

7. What is the level of staff retention and recruitment, and what is being done regarding workforce?

The social care workforce in Cornwall ‘recycles’ around different providers, often returning more than once to providers they have already worked for previously; and a percentage exits the sector altogether. Different providers are working on this in different ways; given the challenges of recruitment I do not intend to share my own solutions which I am trialling at this time. The problems vary anyway, from area to area: transport, cost of driving lessons and car ownership, the impossibility of using public transport, as well
as the difficulty in paying travel/mileage costs at a level which maintains a
car in a reliable condition at all times. Even training requirements, when
other employment sectors do not have such onerous conditions, is a factor,
as is the potential but real risk of criminal prosecution for omissions and
failures such as those which might be caused by the need to ‘rush’ to the
next client, are all deterrents to seeking this sort of employment. Media
coverage of care headlines, together with the perception that this is low
status work for poor pay, is enough for some potentially very good
candidates to feel that a career in care is something they do not wish to be
associated with – the impression often being that carers and care providers,
are generally considered uncaring, if not actually abusive. These things all
affect recruitment, and while appropriate training and robust exposure of
poor practices are vital, at times of labour shortage, these compound the
recruitment challenges.

8. How is the voice of the person in receipt of care (and their families)
heard?
We ask them!

9. How do you see the sustainability and modernisation of care at home
services?
At the moment it is going backwards.

10. What is your biggest lesson has been from this process and/or what they
would do differently if going through a similar one in the future?

Probably not to engage with council funded work at all, without much greater
transparency in the process, and less penalties attached where matters are
outside our control (eg recruitment difficulties), and without adequate
funding which would enable us to attract the best calibre staff.

I think the council has more to learn than the sector. For example, it was
very naïve to believe that staff could be TUPE’d across from non-framework
to framework providers. That would assume that non-framework providers
did not provide any other care, such as to either health or self-funders, or
domestic and other unregulated support. It also assumed that staff had no
loyalty to their employers and would be happy to be ‘transferred’ to another.
Some exited the sector at this time. Unless the business itself was taken
over, or the service users themselves were the employers, a TUPE transfer
could never have applied, and was something CPIC tried to warn about, but
was not listened to, at the time.

11. How has the communication been between those involved?
Not straightforward! Lack of meaningful engagement during the tendering
process, presumably because of fears of legal challenges.
12. Recognising the differences in scales, is there anything that could be learnt from national providers or national representative organisations?

The differences are not just in scale; Cornwall is predominately rural and carers largely need to be car drivers. Plymouth, Exeter, other cities, can have care ‘runs’ where many carers can be non-drivers. That has nothing to do with scale.

Cornwall’s challenge includes a number of factors: as a historically low-wage economy there are relatively more people on HB (housing benefit) and tax credits, than better off parts of the country. This means our existing carers are less able to take on more hours as it is not to their advantage to lose tax credits or HB. More are therefore part time from choice (which also makes childcare arrangements more manageable/affordable). This requires Cornwall to have more ‘numbers’ of staff to cover the same hours of care than other areas where more fulltime personnel are available.

Cornwall is the ‘longest’ county in England but has a relatively low population (the population of the entire county matches just the Exeter travel to work area, where service users are concentrated in a far easier to reach geography, as are the carers – and where even there, they have recruitment challenges; ours are just that much worse). The Cornwall working population has other options open to them, and potential staff are not located in areas of density in sufficient numbers that makes it economically viable to meet the care needs of the disparately located service user population –and certainly not at the funding levels currently provided.
9. How are issues regarding payment and purchase order delays being addressed?

This is really a question for the Adult Care Service who is responsible for the payment and purchase order process. However, there have been significant changes to the processes for payment and purchase orders following feedback from the providers:

- simpler less detailed purchase order was developed and implemented;
- timeframes for the processing of orders was streamlined and regularly reviewed;
- brokers and charging assessment team have tried to ensure the process is as smooth as possible but as with any complex system sometimes this is not as timely as it should be; and
- early this financial year we reduced a delay in postage and sometimes non receipt by e-mailing Purchase orders and not posting (as cryptshared for security these have a time limited life for download and must be retrieved within 10 days).

Alongside the changes and simplification of the system we have developed the Finance Manager Module within Callconfirmlive. This sends data twice a day from MOSAIC our case management system to the provider’s electronic call system. The data is matched and reconciled for payment before being sent back into MOSAIC for payment. This reduces the risk of purchase orders not being received in a timely manner. There are 5 providers live on Finance Manager with a further 5 providers going live in this finance period. Another group of providers are being trained this week for them to start using the system in the New Year. The payments will be significantly quicker than the current 30 day term and much of these are fully automated.

10. What was the cost difference from before the framework to the last 12 months?

This is difficult to look at in isolation as there are a number of factors that influence the overall spend on packages of care, these include:

- Increasing trend of personalisation of budgets meaning the Council commissions less packages of care;
- Significant changes to EIS service in 2014/15 i.e. effectively the Council stopped commissioning new EIS packages of care;
- Change in the charging policy in 2014/15 which meant more people had to pay higher contributions or drop totally out of the Council’s commissioning responsibility; and
- Significant backlogs of reviews were undertaken in 2014/15.

The overall spend on packages of care and personal budgets (before client contributions) for the last two financial years are:
2013/14 - £53,563,233. No. of services users at 31/3/14 – 5,110
2014/15 - £50,842,428. No of services users at 31/3/15 – 4,303

The reduction of £2,720,805 between years cannot be solely attributed to the framework because of the points mentioned above, including the overall reduction in number of service users from 5,110 to 4,303.

11. Have legal challenges been warranted in your opinion?

Yes, the grounds for challenge in respect of Care at Home 1 were sound. We should not have used the evaluation matrix document it constituted unpublished sub-criteria and it rendered our procurement process unlawful. There were no formal challenges made in respect of Care at Home 2.
Section 135/136 of the Mental Health Act: Places of Safety in Cornwall

1. **Section 136 of the Mental Health Act**
   1.1 The Mental Health Act is the law which can be used to admit a person to hospital for assessment and/or treatment for a mental illness. This is known as being 'sectioned'.
   1.2 Under Section 135 of the Mental Health Act, mental health professionals can ask a judge for permission to ensure a person’s home in order to take them to a place of safety for a mental health assessment.
   1.3 Section 136 allows the police to take people to a place of safety when they are in a public place.
   1.4 Both sections can only be applied if the professionals believe the person has a mental illness and is in need of care.
   1.5 A place of safety can be a hospital or a police station.

2. **The national context**
   2.1 Statistics on the use of Section 135 and 136 in the preceding financial year are published annually in October. The Health and Social Care Information Centre (for England and Wales) reported an increase in the use of Section 136 by 2,400 (of 14.1%) to 19,400 compared to the year before.
   2.2 Data released by the National Police Chiefs’ Council in 2015 shows a reduction in the use of police cells from 6,667 in 2013/14 to 4,537 in 2014/15. A reduction of 32%.
   2.3 The number of times people aged under 18 were taken to police custody as a place of safety under Section 136 of the Mental Health Act fell from 256 in 2013/14 to 161 in 2014/15 (37% reduction).

3. **The local picture**
   3.1 In Cornwall there are two police custody suites located in Bodmin and Redruth. The Launceston custody suite closed in October 2015.
   3.2 Cornwall Partnership NHS Foundation Trust (CFT) has a section 136 (place of safety) suite at Longreach House psychiatric hospital in Redruth. The suite can accommodate two adults or one person under the age of 18.
   3.3 CFT and Devon and Cornwall Constabulary have developed a joint protocol to ensure anyone detained under this section of the Mental Health Act receives appropriate care.
   3.4 The protocol came into operation from 1 April 2015.
   3.5 The purpose of the agreement is:
   - to ensure efficient, effective and dignified assessment arrangements for all detainees who need to be removed to a place of safety
• to ensure effective multi-agency oversight for place of safety arrangements within Devon, Cornwall and the Isles of Scilly
• to ensure effective assessment by police officers and or the ambulance service to ensure transport to the most appropriate location
• to ensure the use of a dedicated health place of safety in the majority of occasions
• to ensure the use of police stations is only in exceptional circumstances and where it is medically safe to do so
• to work across organisational boundaries in achieving these intentions.

3.6 The protocol is clear that use of a police cell should only occur in exceptional circumstances after consideration of other second-choice contingencies; such as home address, family or friends. Health professionals will work with the police to identify a suitable contingency plan should a healthcare place of safety be unavailable.

3.7 The protocol will be subject to a multi-agency review every 12 months by the Local Criminal Justice Board peninsula criminal justice mental health meeting.

3.8 In the last 11 months Devon and Cornwall Police recorded 269 detentions under Section 136. Of these nine people (3%) were taken to a custody suite.

4. Recommendation

4.1 To note the information taken by CFT and Devon and Cornwall Constabulary to improve the care and treatment of those detained under section 136 of the Mental Health Act.