Cornwall and the Isles of Scilly Health and Care Partnership

Minutes
Penwith integrated community services stakeholder event, workshop four

Wednesday 19 August 2020
10am to 12.30pm
Virtual meeting via Microsoft Teams

Attendees

- Chris Goninan, chair, Penwith 50+ Forum
- Toni Carver, vice chair, Edward Hain League of Friends
- James Page, regional partnership director south west, NHS Property Services
- Vicky Farrell, Penwith community rehabilitation team, Cornwall Partnership NHS Foundation Trust
- Jeremy Preedy, Citizens Advisory Panel member
- Lynne Isaacs, Edward Hain League of Friends
- Anita Cornelius, integrated care area director, Cornwall Partnership NHS Foundation Trust
- Vanessa Luckwell, council community link officer for Hayle and St Ives
- Debra Cooney, Healthwatch Cornwall
- Kirstine Welch, business support manager – west, Cornwall Partnership NHS Foundation Trust
- Joan Tanner, chair, Edward Hain League of Friends
- Colonel Richard Robinson MBE, councillor, St Ives east
- Angela Andrews, community safety partnership/health commissioning, Cornwall Council
- Lynda McHale, hospital matron, Edward Hain Hospital, Cornwall Partnership NHS Foundation Trust
- Sue Rogers, integrated community manager, Cornwall Partnership NHS Foundation Trust
- Lesley Brooke, West Cornwall Healthwatch
- Dr Dan Rainbow, GP, Stennack Surgery and joint clinical director for Penwith Primary Care Network
- Andrew Mitchell, councillor, St Ives west
- Sue James, member, Cornwall Council Cabinet
- Michelle Carne, support co-ordinator
- Jane Nicholas, head of service - west Cornwall, adult social care, Cornwall Council
- Trevor Bailey, trustee, disAbility Cornwall
- Tish Berriman, managing director, Cornwall Care
- Andrew George, former Lib Dem MP for St Ives

NHS Kernow team

- Kate Mitchell, programme lead

- Rachel Murray, locality development manager, west
- Dr Neil Walden, clinical lead
- Hollie Bone, engagement manager
- Michelle Smith, team support assistant
- Louise Moore, patient and public involvement assistant
- Andrea Darby, project assistant for west locality development

Introduction and recap from workshop three

Kate Mitchell welcomed everyone to the virtual meeting. She explained to attendees how they could indicate if they wanted to speak, how to mute microphones, use the chat box to make comments etc. Kate gave apologies from Carolyn Rowe, David Raymer, Dr Katrin Tunstall, Dr Anne Maskell, Joe Croft, John Garman, Michael Miller and Samantha Jacobs.

Kate expressed her thanks to the attendees for their understanding for the need to postpone the planned workshop on 16 March due to COVID-19 and Government guidance about holding public meetings. She then shared the first slide with the aims for the workshop as follows:

1. Share and understand the outcomes of the evaluation of the short listed option.
2. Provide information on service changes since COVID-19.
3. Share the next steps.

Dr Neil Walden explained that the work undertaken so far will be considered at the NHS Kernow Governing Body in October for a view on the next steps.

Rachel Murray gave examples of some of the positive changes that have taken place since COVID-19. She acknowledged the significant amount of work undertaken and the prompt and responsive services that have been put in place to improve out of hospital care and support.

Some of the new ways of providing care and support

- **Remote access to care:** GP practices implementing solutions such as e-consult, video consultations and telephone support to reduce face-to-face contact and provide care remotely. Feedback from surveys indicates that the majority have been happy with this, although it should be recognised that not everyone has digital access.
- **Drive-through blood testing clinic:** The first ever clinic opened at Costa in Penzance where people requiring regular blood tests for medication control did so from the safety of their car.
- **Clinical assessment and treatment units:** Set up in West Cornwall Hospital and Camborne Redruth Community Hospital to rapidly diagnose, assess and treat people to help keep them safe at home rather than needing an acute hospital bed.

- **Community co-ordination centres (CCC):** Integrated health and social care teams were mobilised and linked to primary care, 8am to 8pm, 7 days a week to improve coordination of care.
- **Support to care homes:** Examples of primary care, community teams and acute staff coming together to support care homes through COVID-19 outbreaks.
- **A single electronic referral process:** Developed for all referrals to go via the CCCs to streamline the process and make it easier for both people making and receiving the referral.
- **Consultant eldercare/ geriatrician support:** Allocated to every PCN to allow more expert support to be provided in the community allowing more people to be cared for at home.

Dr Walden gave a recap of the last workshop and the long list of nine identified options that were jointly appraised. At that community workshop it was agreed to short-list one option for full evaluation, namely to re-instate 12 inpatient beds and continue existing community clinics in a fire safety compliant and refurbished building.

Kate reminded the attendees of the evaluation process that had been agreed at previous workshops. She reminded the group that there were 13 evaluators, with two local community representatives-a councillor and a member of West Cornwall HealthWatch. Evaluators were given 3 weeks to individually evaluate the short listed option and had opportunities to view a video of the hospital and tour the building prior to evaluation. A significant amount of background reading was undertaken prior to individual evaluation, followed by a 3 hour meeting for the group moderation process. All individuals gave written rationale for their scoring. Kate explained that 17 of 21 scores were agreed at that group meeting. The minimum scores for safety, financial affordability and sustainability were not met. As agreed prior to the evaluation, four NHS Kernow Executive team members then met to make a final decision on the 4 remaining scores not agreed on at the group moderation.

Dr Walden noted that the work completed to date has been robust and inclusive. There has also been additional scrutiny provided by NHS England and Improvement and The Consultation Institute. The slides with the scores for each of the 21 evaluation criteria were shared with some of the evaluator's comments. It was acknowledged that the slides had a lot of information on them, but we wanted to share the key comments, and there will be opportunities for people to provide feedback to the project team after this meeting.

Kate Mitchell then went through the scores allocated to each of the 21 criterion and the slides showed the key rationale for these scores provided by the 13 evaluators. It was noted that many of the evaluators' observations were highlighting themes that had been discussed in previous workshops. There were both positive and negative comments. More detail is available in the workshop slides. The scores that the evaluation process agreed upon with the 13 evaluators (including two local representatives) are below.

Evaluation scores

Quality
1a. Effectiveness = 1
1b. Experience = 1
1c. Responsiveness = 0
1d. Safety (minimum score of 2 required) = 0. Minimum score not met.

Access
2a. Impact on individual choice = 1
2b. Distance, cost and time to access services = 1
2c. Equity of access = 0
2d. Extended access = 1
2e. Equity of provision = 0

Workforce
3a. Workforce supply = 1
3b. Workforce upskilling = 1
3c. New ways of working = 1

Deliverability
4a. Timescales and ease to deliver = 1
4b. Sustainability = 1

Environment
5a. Climate management = 1
5b. Environment of service delivery = 0

Financial
6a. Value for money = 1
6b. Affordability (minimum score of 2 required) = 0. Minimum score not met.
6c. Financial sustainability (minimum score of 2 required) = 0. Minimum score not met.

Wider impact
7a. System impact = 0
7b. Community impact = 1

Kate reiterated that the rationale beside each score is a representative selection of the evaluator comments. Dr Walden then summarised the total score as 13 out of 84. The minimum score was not met for safety, financial affordability or sustainability. This means that the evaluation process has determined that the option to re-instate 12 inpatient beds and continue existing community clinics in a fire safety compliant and refurbished building at Edward Hain community hospital was not viable.

Dr Walden explained that the co-development of all the work to date will be considered by various meetings- the multi-agency project group together with the

South West Clinical Senate and NHS England and Improvement and NHS Kernow Governing Body. There will also be a meeting with Adult Social Care Overview and Scrutiny Committee to discuss the findings. We are aiming to take the findings and recommendations to NHS Kernow Governing Body in October.

Dr Walden asked for any comments and questions from attendees. It was generally agreed that the result was not a surprise, but that the overall score was lower than expected. It was noted that, dependent on the decisions made by NHS Kernow Governing Body (the decision making body for this project), that the re-location of the existing community clinics would need to be developed. Any necessary work to consider this (should this be required), would involve engagement with those individuals who use and deliver the clinics. Dr Walden explained that it is not the remit of this group to make that decision; however, the Penwith Primary Care Network would help progress this.

It was felt that issues over the recruitment and training of staff may have "overweighted" the scores. The question was also raised whether the criteria related to both inpatient and community clinics.

Some attendees felt that this has been an unnecessarily lengthy process with an outcome that could have been foreseen in 2016. A number of attendees felt it is important to retain any capital receipt available should there be a decision that Edward Hain community hospital is surplus to health and care service delivery requirements and that a sale is made.

Kate Mitchell acknowledged that the evaluation did produce surprisingly low scores. Kate explained that the scoring of the option included consideration of the existing community clinics as well as inpatient beds. The option that was evaluated was to 'reinstate the 12 inpatient beds and continuation of existing community clinics in a fire safety compliant and refurbished environment'. It was also noted that some work was undertaken to investigate if other services wanted to hold clinics at the hospital such as the children and early hub family service. This was discussed as part of the long listed options, but the site was not deemed suitable. No other services had raised any interest in using the available clinic space. Regarding the question of "overweighting", Kate reminded the group that the process had been discussed and agreed in advance at previous workshops to ensure that stakeholders were happy with the process, and it was decided together that a weighting process would not aid transparency. It had been decided together that there would be no essential scores so that options could not be discounted even if they did not meet the finance criteria alone. But, it was agreed that there would be minimum scores for safety and financial affordability and sustainability. It was also acknowledged that criteria such as staffing and safety cannot be considered in isolation as they overlap.

It was also noted that there have been significant changes since 2016 when the inpatient beds first closed-the Edward Hain winter reablement pilot, Embrace Care Diagnostic, changes in providing step up beds at West Cornwall Hospital and the South West Clinical Senate's community hospital recommendations. These

recommendations included a minimum number of 16 beds for a safe, reliable and efficient staffing. All of these aspects have helped to inform this process.

Attendees praised the methodology and thoroughness of the process, but considered that it had become too fixated upon an inadequate out-of-date building, recognising that a decision needs to be made on the building. Members of the group were committed to ensuring the continued longer term planning of care and support across Penwith and the West builds on all the learning and evidence gathered through this process, to ensure health and care services meet the needs of local people.

The necessity for 'step up' and 'step down' care for older people who have to travel considerable distances was noted. Dr Walden advised that work is still ongoing reviewing factors such as bed type and location, care closer to home, more efficient use of inpatient beds, developments of step up beds in West Cornwall Hospital and building on the aspects of remote delivery of care that have produced positive outcomes for people since COVID-19. Dr Walden noted that large amounts of data have been generated which will inform future planning and decision-making. Drs Rainbow and Tunstall are now leading Penwith Primary Care Network and will continue the local planning and delivery of services.

Attendees praised the hard work of the community services during COVID-19, with direct admissions to West Cornwall Hospital rather than Treliske for local people, keeping people closer to home. It was recognised that the location of reablement support is important to ensure travel is kept to a minimum especially as reablement is not always possible at home. It was questioned why local sports centres and gyms cannot be accessed for rehabilitation and reablement. The response is that these have been considered, but local facilities need to be resourced and supported appropriately to meet local health needs. For rehabilitation any gym equipment needs to be secured permanently to the floor for safety reasons, and not all gyms can provide this. Public Health England is working closely with the voluntary sector and private gyms on initiatives to try and prevent frailty.

Kate Mitchell noted that discussions on community needs and priorities were discussed at previous workshops, and those conversations are ongoing. The work to deliver improved services will continue. The group heard at the start of the meeting that COVID-19 has kick-started improvements in co-ordination of community services and the enhanced model of care continues to progress.

It was explained that the community co-ordination centres that were set up as part of the COVID-19 response will continue and that local teams are hoping to have a satellite centre in Hayle to co-locate health and social care staff.

After a short comfort break the meeting recommenced. Kate Mitchell presented a slide showing how we have worked together to:

1. Co-develop the process to determine how we create options for Edward Hain hospital and evaluate those.

2. Co-develop a long list of options and appraisal of those to agree which to short list to evaluate.
3. Provide local representation to the development of the evaluation process, criteria and scoring.
4. Provide local representation to the evaluation of the short listed option.

She reiterated that the project group has been very grateful for people's input and endorsement of the process and that local representation has been invaluable at all points throughout the process.

Dr Walden noted that although the evaluation process states there are no viable or deliverable options for Edward Hain community hospital, the learning will be captured from this process and work will build on this through the Penwith Integrated Care Forum, the primary care networks and the West Integration Board. Stakeholders will be kept informed. He acknowledged the valuable input of all involved, particularly the League of Friends of Edward Hain hospital over many years. Dr Walden said that he would encourage attendees to become involved with Penwith Integrated Care Forum if they would like to have their views heard about future service planning and delivery.

The future of Edward Hain Hospital itself was then discussed.

James Page, NHS Property Services (NHS PS) explained that on the assumption that NHS Kernow Governing Body declare the building surplus, it will be handed back to NHS Property Services and sold, probably (given its location) for residential use. Buildings are only valued once they are declared surplus as valuations go out of date quickly. As explained at previous workshops, capital receipts go back to the central budget ordinarily. James said that he would be happy to progress initiatives within the local area for other NHS PS owned buildings (provided these initiatives were agreed by NHS Kernow and the wider system). He is hopeful to be able to support local work to recycle capital receipts should a sale be the option-which is all dependent on the decision yet to be made by NHS Kernow Governing Body.

Whilst no decision has been made about the future of Edward Hain community hospital, some attendees were keen to see local investment into new estate rather than any spend on other buildings which should be maintained in any case, and also expressed preference that the total capital receipt be recycled locally, rather than a sum of it. It was also noted that the emphasis should be on what the community needs, e.g. an integrated service closer to home. This would form part of the work that the West Integrated Care Area and Penwith Primary Care Network are taking forward.

James Page confirmed (following a question about gifting the hospital by the Hain family) that Edward Hain is now part of the NHS estate. He said he was aware of the strong emotional ties felt to it by the people of St Ives, as expressed again by attendees. This feeling was acknowledged by Dr Walden as was the importance of working with the people of St Ives to meet their community needs and priorities.

Dr Walden stated, following a question on Government funding for hospitals that any new investment into hospitals will be announced centrally. We do not have any information on that at present. However, integrated care areas will have input into that process and any discussions will be based on local population need.

An Estates Strategy is produced annually to look at where capital funding is needed. Provider organisations are part of that group, also Cornwall Council and NHS Property Services. Dr Walden explained that the integrated care areas and primary care networks are now formally linked in to those discussions. Attendees agreed that from this point it is important to start looking forward and focus on work that needs to be done.

Kate Mitchell advised that the minutes and slide deck of this meeting will be circulated to attendees and the wider stakeholder group and also posted on NHS Kernow's website. View the minutes and slide deck for this meeting. The next steps are as follows:

1. Briefings with health and adult social care and the Overview and Scrutiny Committee.
2. Assurance reports and meetings with NHS England and Improvement and the South West Clinical Senate.
3. NHS Kernow Governing Body to receive the findings and recommendations from this work and determine the next steps-hopefully in October.

Kate then asked for all feedback using the email kccg.engagement@nhs.net , as this will form part of the recommendations to go to the Governing Body. Dr Walden noted the challenges raised by attendees regarding step up and step down beds and said that these should be addressed by the Primary Care Network. Attendees asked for a copy of the presentation slides shown today.

Dr Rainbow explained that he and Dr Tunstall took over from Dr Walden in April as co-clinical directors of Penwith Primary Care Network. The health and care landscape has changed considerably in the last few years and most noticeably since COVID-19 and positive improvements have been made. There is potential at Stennack Surgery to develop services as there is space for other clinics and for reablement functions if that is what the community decide they want. Dr Walden stated that he has great confidence in the new leadership. It was noted that from a social care perspective that we are presented with a moment in time to work together with our communities to truly deliver care closer to people's homes.

Kate Mitchell expressed her thanks to everyone and in particular her gratitude to Dr Walden providing excellent clinical leadership, and staying beyond his original retirement date to help guide the group. She thanked everyone for their views and input and said it would be much appreciated in taking plans for care forward. NHS Kernow Governing Body will now consider the co-production work that has been completed and the outcome of the evaluation, and determine the next steps in their October meeting.