Phil Norrey
Chief Executive

To: The Chairman and Members of the Health and Wellbeing Scrutiny Committee

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

(See below)

Your ref :
Our ref :

Date : 31 October 2016
Please ask for : Gerry Rufolo, 01392 382299

Email: gerry.rufolo@devon.gov.uk

HEALTH AND WELLBEING SCRUTINY COMMITTEE

Tuesday, 8th November, 2016

A meeting of the Health and Wellbeing Scrutiny Committee is to be held on the above date at 2.00 pm in the Committee Suite, County Hall to consider the following matters.

P NORREY
Chief Executive

A G E N D A

1 Apologies for Absence

2 Minutes

Minutes of the meeting held on 19 September 2016 (previously circulated).

3 Items Requiring Urgent Attention

Items which in the opinion of the Chairman should be considered at the meeting as a matter of urgency.

4 Public Participation: Representations

2.05pm
Members of the public may make representations/presentations on any substantive matter listed in the published agenda for this meeting, as set out hereunder, relating to a specific matter or an examination of services or facilities provided or to be provided.

MATTERS FOR CONSIDERATION

[*NB. Please note that the times shown below are indicative and while every effort will be made to adhere thereto they may vary although, normally, items will be taken before the time shown*]

5 Referral to the Secretary of State for Health and Independent Review Panel Advice: Torrington: For Information (Pages 1 - 12)

2.20 pm

Letter from the Secretary of State, attached

6 Notice of Motion: Referral from Cabinet 12 October 2016

2.30pm

The Cabinet referred the following to this Committee for consideration:

(a) Proposed Cuts to Devon Health Services and Impacts on Patients (Councillor Biederman)

'This Council is deeply concerned about the impact the proposed cuts to Devon health services will have on patients – especially the loss of whole departments including maternity services at North Devon District Hospital - and massive reduction in acute and community hospital beds across Devon, as set out in the sustainable transformation plan.

This Council also recognises that Governments have deliberately not provided the NHS with the adequate level of funding and now calls on local MPs to lobby government ministers to urgently and significantly increase the level of funding to the NHS, in order to protect our precious health services for current and future generations'.

(b) NHS Success Regime (Councillor Greenslade)

'County Council believes that the NHS Success Regime project for Devon is now seriously flawed and accordingly calls on the Secretary of State for Health and NHS England to cancel it forthwith. County Council further calls on Government and NHS England to firstly address the issue of fair funding for our area and to ensure the general election promise of an extra £8 billion of funding for the NHS is taken into account when assessing the claimed deficit for Devon NHS services.

Until funding issues are addressed it is not possible to decide whether or not there is a local NHS budget deficit to be addressed. Unnecessary cuts to local NHS budgets must be avoided!

Devon MP's be asked to support this approach to protecting Devon NHS services"

The Cabinet had resolved

"that the aforementioned Notices of Motion be referred to the Heath & Wellbeing Scrutiny Committee for consideration and report back"

7 Devon Sustainability and Transformation Plan

Scrutiny Officer to report on representations received by this Committee

a Model of Care: Spotlight Review (Pages 13 - 22)

Report of the Spotlight Review (CS/16/43) attached

b Devon Sustainability and Transformation Plan (Pages 23 - 26)

Report of the STP Team for NEW Devon and South Devon and Torbay CCGs, attached

c Your Future Care: Consultation (Pages 27 - 114)

Report of NEW Devon CCG, attached

8 Co-Location of Stroke Services in Northern Devon (Pages 115 - 122)

3.10 pm

Report of the Northern Devon Healthcare Trust, attached

9 NHS 111 and Out of Hours Cover (Pages 123 - 128)

3.30 pm
Report of NEW Devon Clinical Commissioning Group, attached

10 Work Programme

In accordance with the previous practice, Scrutiny Committees are requested to review the list f forthcoming business (previously circulated) and to determine which items are to be included in the Work Programme. The Work Programme is also available on theCouncil's website at http://www.devon.gov.uk/scrutiny_programme.htm

The Committee may also wish to review the content of the Cabinet Forward Plan (available at http://new.devon.gov.uk/democracy/how-the-council-works/forward-plan/) to see if there are any specific items therein it might wish to explore further.

MATTERS FOR INFORMATION

11 Information Previously Circulated

Below is a list of information previously circulated for Members, since the last meeting, relating to topical Health and Wellbeing developments including matters which have been or are currently being considered by this Scrutiny Committee.

PART II - ITEMS WHICH MAY BE TAKEN IN THE ABSENCE OF THE PUBLIC AND PRESS

Members are reminded that Part II Reports contain confidential information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s).
Members are also reminded of the need to dispose of such reports carefully and are therefore invited to return them to the Democratic Services Officer at the conclusion of the meeting for disposal.

MEMBERS ARE REQUESTED TO SIGN THE ATTENDANCE REGISTER

Membership
Councillors R Westlake (Chairman), A Boyd, J Brook, C Chugg, C Clarance, P Colthorpe, P Diviani, R Gilbert, B Greenslade, G Gribble, R Julian, E Morse, D Sellis (Vice-Chair), E Wragg and C Wright Representing District Councils Councillor J Christophers
Declaration of Interests
Members are reminded that they must declare any interest they may have in any item to be considered at this meeting, prior to any discussion taking place on that item.
Access to Information
Any person wishing to inspect any minutes, reports or lists of background papers relating to any item on this agenda should contact Gerry Rufolo on 01392 382299 Agenda and minutes of the Committee are published on the Council's Website.
Webcasting, Recording or Reporting of Meetings and Proceedings
The proceedings of this meeting may be recorded for broadcasting live on the internet via the 'Democracy Centre' on the County Council's website. The whole of the meeting may be broadcast apart from any confidential items which may need to be considered in the absence of the press and public. For more information go to: http://www.devoncc.public-i.tv/core/ In addition, anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chairman. Any filming must be done as unobtrusively as possible from a single fixed position without

the use of any additional lighting; focusing only on those actively participating in the meeting and having regard also to the wishes of any member of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chairman or the Democratic Services Officer in attendance so that all those present may be made aware that is happening.

Members of the public may also use Facebook and Twitter or other forms of social media to report on proceedings at this meeting. An open, publicly available Wi-Fi network (i.e. DCC) is normally available for meetings held in the Committee Suite at County Hall. For information on Wi-Fi availability at other locations, please contact the Officer identified above.

Public Participation

Devon's residents may attend and speak at any meeting of a County Council Scrutiny Committee when it is reviewing any specific matter or examining the provision of services or facilities as listed on the agenda for that meeting.

Scrutiny Committees set aside 15 minutes at the beginning of each meeting to allow anyone who has registered to speak on any such item. Speakers are normally allowed 3 minutes each.

Anyone wishing to speak is requested to register in writing with Gerry Rufolo (gerry.rufolo@devon.gov.uk) by 0900 hours on the day before the meeting indicating which item they wish to speak on and giving a brief outline of the issues/ points they wish to make.

Alternatively, any Member of the public may at any time submit their views on any matter to be considered by a Scrutiny Committee at a meeting or included in its work Programme direct to the Chairman or Members of that Committee or via the Democratic Services & Scrutiny Secretariat (committee@devon.gov.uk). Members of the public may also suggest topics (see: https://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/scrutiny-work-programme/

All Scrutiny Committee agenda are published at least seven days before the meeting on the Council's website.

Emergencies

In the event of the fire alarm sounding leave the building immediately by the nearest available exit, following the fire exit signs. If doors fail to unlock press the Green break glass next to the door. Do not stop to collect personal belongings, do not use the lifts, do not re-enter the building until told to do so.

Mobile Phones

Please switch off all mobile phones before entering the Committee Room or Council Chamber

If you need a copy of this Agenda and/or a Report in another format (e.g. large print, audio tape, Braille or other languages), please contact the Information Centre on 01392 380101 or email to: centre@devon.gov.uk or write to the Democratic and Scrutiny Secretariat at County Hall, Exeter, EX2 4QD.

Induction loop system available

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

020 7210 4850

POC_1043606

Councillor Richard Westlake
Chair, Devon County Council Health
and Wellbeing Scrutiny Committee
County Hall
Topsham Road
Exeter
Devon
EX2 4QD

28 SEP 2016

Dear Cllr Westlake,

Reconfiguration of Torrington Community Hospital – IRP Advice on Referral from Devon County Council Health and Wellbeing Scrutiny Committee

I am responding to your letter of 21 July 2016 referring proposals to me concerning the reconfiguration of inpatient beds at the Torrington Community Hospital.

You referred this case to me on the grounds that you believe local changes are not in the best interests of patients. As you know, I asked the Independent Reconfiguration Panel (IRP) for its initial advice on receipt of your referral.

The IRP has now completed its initial assessment and shared its advice with me. After careful consideration, the IRP is of the view that your referral does not warrant a full review and I accept the IRP's advice in full.

IRP advice

The IRP has considered the issues you raise in your letter. It is evident that the hospital is a much-appreciated local institution and residents of Torrington and Torridge district are understandably keen to see that it remains a part of healthcare provision for the area.

The NHS has a duty to consider how it can provide the best care for people, taking account of modern technology and advancements in medical practice, through safe,

sustainable and accessible services. The Torrington *Community Cares* test of change was initiated for precisely those reasons.

I understand that early engagement with the local community could have been improved upon. The NHS has acknowledged this and has taken steps to address matters since.

It is right that the focus now must be on the future and learning from mistakes of the past. I wholly support the suggestions by the IRP for further action by the NHS working with the local community.

A copy of the full advice is appended to this letter and will be published today on the IRP's website at www.irpanel.org.uk.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

IRP

6th Floor
157 – 197 Buckingham Palace Road
London
SW1W 9SP

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

23 September 2016

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE FOR HEALTH
Report by Devon County Council Health and Wellbeing Scrutiny Committee
Torrington Community Hospital

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Richard Westlake, Chairman Devon County Council Health and Wellbeing Scrutiny Committee (HWSC). NHS England provided initial assessment information. A list of all the documents received is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that **this referral is not suitable for full review because further local action by the NHS with the Council can address the issues raised.**

Background
Torrington Community Hospital, in the north Devon district of Torridge, is one of 17 community hospitals currently run by North Devon Healthcare NHS Trust (NDHT). The original hospital building dates back to 1908 with extensions added in the 1980s. Up to autumn 2013, it provided general medical inpatient services from ten beds as well as a range of outpatient services and clinics for a largely rural population (around 64,000 in Torridge District) that is older than the national average. Future population growth is predicted to be greatest amongst people of pensionable age and particularly amongst those aged 85 plus.
A longstanding programme of change, initiated by the former South West Strategic Health Authority in 2010, had sought to test different models of community healthcare provision with the aim of increasing community nursing and providing more care in people's homes.

Consequently, over a gradual period, local community services had been strengthened and Torrington Community Hospital experienced a declining number of admissions. As patient admissions reduced, this raised concerns for NDHT about maintaining inpatient staffing and quality of care.

In July 2013, the NHS North, Eastern and Western Devon Clinical Commissioning Group (CCG) commenced a joint *"Torrington Community Cares"* test of change. A document, *Transforming Torrington Together*, was published on 4 July 2013 setting out the rationale for the test of change and seeking to engage the community in the design of future local services. The test involved temporarily suspending the ten Torrington hospital beds for six months and replacing the inpatient service with an enhanced model of community care to people in their own homes. Proposals also included the possibility of additional clinic services being delivered locally in Torrington. Patients for whom a community hospital admission was still appropriate (around two per month) would be admitted to neighbouring community hospitals.

In light of significant local concern about the loss of the 'safety net' of inpatient beds during the test of change the CCG and NDHT postponed the start of the test from September to October 2013 and kept open six beds for the first eight weeks. A supporting document, *Torrington: Meeting local needs*, setting out the case for change was published in October 2013. A rapid evidence review, *Care closer to home*, was published by Public Health Devon in November 2013. Also in November 2013, at the end of the eight week period, the CCG and NDHT evaluated the use of the beds and concluded that, with only three admissions during the period, the beds could safely be closed for the remainder of the test. The test of change concluded on 31 March 2014. The beds remained closed while final evaluation data covering the six month trial was collated.

The evaluation concluded that the new model was as good or better quality in terms of health and social care outcomes than the service that had existed before. Fewer hospital admissions had been necessary and a reduced length of stay was required for those who had been admitted to hospital. No adverse impact on local A&E or ambulance services had been identified.

In May 2014, Healthwatch Devon published the results of a survey, *Torrington 200, a report with recommendations concerning Torrington Community Hospital.* The report highlighted the high regard with which the hospital was held by local people and the need for greater dialogue and communication in planning future healthcare for the Torrington area. An NHS response and action plan to five recommendations made in the report was published in June 2014.

Public engagement activity continued during summer 2014 providing stakeholders and the public the opportunity to discuss the project in more detail. As part of this process, a community-led Oversight Group was established to examine the data being collected.

The HWSC had received presentations from NHS representatives prior to and during the test period and on 16 June 2014 considered a report on the evaluation and engagement activity. The Committee noted the report and requested that further progress reports be provided over the next twelve months.

NHS representatives met Geoffrey Cox MP for Torridge and West Devon and community leaders on 21 July 2014 to discuss the outcome of the test of change and next steps. Following that meeting, it was agreed that four remaining tasks would be completed before a final decision was made:

- additional time for the community to provide further feedback
- a dataset to be provided to the Oversight Group to enable the group to make recommendations to the relevant NHS boards
- a final public meeting to discuss the project
- an independent review of the evaluation data - which was subsequently undertaken by Dr Helen Tucker

Dr Tucker's report was submitted in September 2014. Overall, the report found that the evaluation had been carried out *"in a sufficiently accurate and robust way with regard to data analysis and interpretation of the wider health system"*. However, it also noted *"a fundamental disconnect between the formal scope of the evaluation, the nature of the engagement and the concerns of the local community"*.

The public meeting, chaired by Geoffrey Cox MP, was held in November 2014 before the Board meetings of NDHT and the CCG on 25 and 26 November 2014. A number of documents were provided to both Boards including updated evaluation data with patient feedback, the Tucker report and the views of the Oversight Group. The Boards agreed to provide community services using the enhanced model of care in place of the beds in Torrington Community Hospital which would be closed, and to support a change in use of the building to deliver additional services for Torrington and its parishes from the hospital site.

A progress report from the CCG was considered by the HWSC on 16 January 2015 and the CCG was asked to provide additional information to enable the Committee to evaluate whether anticipated outcomes were being delivered. Further progress reports were provided to HWSC meetings in March 2015 – in which the Committee considered a Member Investigation report from Cllr Andy Boyd – and June 2015. The June meeting resolved that consideration be given to establishing a Task Group which was subsequently formed in September 2015 to review the evidence and process by which decisions about Torrington Community Hospital had been made, to clarify the principles on which a referral to the Secretary of State for Health could be made and to consider next steps against a backdrop of change in community hospital care in Devon.

The Task Group undertook witness sessions and visits to Torrington from September 2015 onwards before reporting back to the HWSC at its 20 June 2016 meeting. The Committee

noted some outstanding details and comments requiring further consideration by the Task Group. It was resolved to refer the Task Group report to the Secretary of State for Health subject to the endorsement by the Committee of a revised draft. Referral was made in a letter from Cllr Richard Westlake, HWSC Chairman to the Secretary of State dated 21 July 2016. The letter references the concerns of local residents, especially the local campaign group Save The Irreplaceable Torrington Community Hospital (STITCH).

Torrington Community Hospital now operates as a health and wellbeing hub offering outpatient services including gynaecology, ear nose and throat, breast clinic and physiotherapy. Development of the hub continues to be considered through a Health and Wellbeing Steering Group established in June 2015 and drawing membership from councils, NHS including general practice, social care and the voluntary sector.

Basis for referral
The HWSC's letter of 21 July 2016 states:

"The item is referred on the grounds that the authority considers that the proposal is not in the interests of the health service in its area."

IRP view
With regard to the referral by Devon County Council HWSC, the Panel notes that:

- the *Torrington Community Cares* test of change was part of a longstanding programme to test different models of community healthcare provision in Devon
- the test of change followed a period of strengthening community services and declining admissions at Torrington Community Hospital which raised concerns about the quality and sustainability of the inpatient service
- the test of change commenced in October 2013 and concluded in March 2014
- the final decision to close inpatient beds and provide community services through an enhanced model of care was taken in November 2014
- despite evaluation data demonstrating positive outcomes from the test of change, public concern about the future development of community services in the area and more widely remains
- evidence suggests that early engagement and consultation activity was unclear in purpose and undermined the confidence of the local population – the NHS has acknowledged this and taken steps to address the situation going forward
- services in the area now come within the consideration of the NEW Devon Success Regime – the Task Group's report emphasizes the need for the views of local people to taken into account when planning changes to healthcare in Devon

Advice
The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel does not consider that a full review would add any value. Further local action by the NHS with the Council can address the issues raised.**

From the documentation provided to the IRP in relation to this referral, it is evident that Torrington Community Hospital and related services have been the subject of numerous considerations, reviews, reports and evaluations. Clearly, the hospital is a much-appreciated local institution and residents of Torrington and Torridge district are understandably keen to see that it remains a part of healthcare provision for the area.

The NHS, equally, has a duty to consider how it can provide the best care for people, taking account of modern technology and advancements in medical practice, through safe, sustainable and accessible services. The *Torrington Community Cares* test of change was initiated for precisely those reasons.

The regulations under which this issue was referred to the Secretary of State do not specify a time limit by which a referral must be made. The test of change began in October 2013 and the final decision to close the inpatient beds at Torrington Community Hospital was taken in November 2014. Since then, the new model of enhanced home care has continued and the hospital building now operates as a health and wellbeing hub offering a variety of outpatient services. The HWSC has chosen to scrutinise progress, including through its Task Group, before concluding that the case has not been made to demonstrate that changes to Torrington Community Hospital are in the best interests of patients in Torrington.

It is perhaps surprising that nearly three years after new community services were introduced and the beds closed, further work is still required to convince the local population that the new service is a better model than the previous one. While further work in that respect evidently is still required, the re-introduction of inpatient beds to Torrington Community Hospital cannot at this late stage be a viable option for consideration.

Much of the continuing anxiety can no doubt be attributed to the fact that early engagement with the local community did not get off to the best of starts. The Tucker report identified the *"fundamental disconnect between the formal scope of the evaluation, the nature of the engagement and the concerns of the local community"*. To its credit, the NHS has acknowledged its failings at the start of the process and has taken steps to address matters since – the Tucker report was itself commissioned by the NHS after discussions with local representatives. The fact that referral was not made on the grounds of flawed consultation with the HWSC reflects the efforts that the NHS made to involve the Committee and keep it informed of progress.

The focus now must be on the future and learning from mistakes of the past in moving forward. The model of care described in the documentation appears to reflect the national direction of travel towards integrated health and social care. It offers potential for flexibility with bespoke packages of care and the benefits of integrated care across agencies including social services and the voluntary sector. The NHS should continue to explore and develop these facets in collaboration with communities, key groups and those with a special interest to build a model of care around their needs. In doing so, the NHS could usefully provide a

picture of how local services will respond to the predicted growth of an ageing local population, including the role Torrington Community Hospital will fulfil. But it may also be necessary to be up-front about the realities and trade-offs of service change. Any change has the potential to result in gains for some – hopefully the majority - and losses for others. A key lesson from Torrington is to be clear and specific about which patients will likely continue to need inpatient care and how their needs will be met in the future. Particularly in a rural setting, travel and access will always be a significant concern even if only for a relatively small number of people. Recognising such concerns, and where possible mitigating for them, will help to calm local anxieties and build confidence.

Services across the area are now under consideration within the NEW Devon Success Regime. Proposals being drawn up under the Success Regime were not part of the evidence submitted to the IRP so it is unclear to the Panel whether or not Torrington constitutes a pilot for other changes to services in Devon. Either way, clarity on what is proposed for the future is now required both for Torrington and the surrounding area and more widely across north, east and west Devon.

There are lessons to be learnt from the Torrington experience, there is also insight to be gleaned from models that have been developed in other parts of the country, for example, through the Vanguard programme. Those lessons and insight should be used to develop a model of care that genuinely reflects and meets the needs of local people. It should be developed through a process of ongoing engagement and involvement with communication that provides clarity and ensures that local people can influence the outcome.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

APPENDIX ONE

LIST OF DOCUMENTS RECEIVED

Devon County Council Health and Wellbeing Committee

1 Letter from Cllr Richard Westlake, Chairman Devon County Council HWSC, 21 July 2016
Attachments:
2 Timeline of scrutiny involvement
3 Devon County Council HWSC relevant minutes
4 Reports in chronological order from the NHS on Torrington
5 Cllr Andy Boyd, member report
6 NHS response to member report
7 Health Watch: Torrington 200 A report with recommendations concerning Torrington Community Hospital
8 Report from Dr Helen Tucker
9 Public Health rapid evidence review
10 Scrutiny Task Group terms of reference
11 Scrutiny Task Group report on Torrington
12 Scrutiny report with attachments, 26 January 2015
13 Letter from NHS re HWSC, 20 June 2016

NHS

1 IRP template for providing initial assessment information
Attachments and links:
2 *Meeting Local Needs*, consultation document, October 2013
3 Archive of published material in relation to Test of Change and supporting engagement
4 North Devon Healthcare NHS Trust Board papers and minutes for meeting 25 November 2014
5 NHS Northern, Eastern and Western Devon Clinical Commissioning Group Locality Board papers for meeting 26 November 2014
6 Minutes of above meetings
7 Equality impact assessment submitted for Northern Locality Board meeting
8 Slide used for NHS England checkpoint discussion, 16 April 2015
9 *Care Closer to Home*, Northern Locality strategy document
10 Engagement timeline
11 Press release, November 2013
12 Heath Watch 200 report
13 Test of Change Oversight Group terms of reference
14 Test of Change Oversight Group final report
15 Announcement on extension of patients' comments on test of change
16 Webcast of HWSC meeting, June 2016
17 Joint Strategic Needs Assessment 2016, Great Torrington
18 NDHT estates strategy, 2 August 2016

19 NDHT CQC reports 2014

Health and Wellbeing Scrutiny Committee

Sustainability and Transformation Plan Model of Care Joint Spotlight Review

November 2016

1. Introduction

1.1 The Health and Wellbeing Scrutiny Committee and the People's Scrutiny Committee from Devon County Council met with the Torbay Community Services Review Panel and the Plymouth Wellbeing Scrutiny Committee on the 5th October for a spotlight review. The review forms part of the on-going work to understand and scrutinise the activities that make up the Sustainability and Transformation Plan (STP) and the changes in localities that follow this plan.

1.2 The STP is a nationally required plan to set the future direction for local health services. Across the Country there will be 44, one covering each area as determined by Central Government. In Devon this area covers the North, East and West Clinical Commissioning Group and the South Devon and Torbay Clinical Commissioning Group. It also spans the areas covered by Devon County Council, Torbay Council and Plymouth City Council. To take this into consideration the spotlight review had all three authorities and both the CCGs present.

1.3 This spotlight review was set up to enable greater understanding of principles that underpin the changes that are anticipated. The focus of the session was to further explore the rationale for change and to openly explore what the positive and negative aspects of change might be. The stated objectives of the meeting were to:

- Members of all three authorities to clearly establish what the new model of care is.
- Members to ascertain what will be the impact of changes to the person receiving care.
- Scrutiny to undertake a 'SWOT' analysis of the model of care to be used as required in each authority.

1.4 This spotlight review does not constitute a joint committee. It is the intention that a short report will be produced following the spotlight review which can then be considered by each authority's relevant Scrutiny Committee. This investigation has not undertaken a detailed review of the consultation process or reviewed changes from the Success Regime, CCGs or STP including looking at specific hospitals. This is anticipated to be considered on a local level.

1.5 The format of this one-off meeting was designed to create the conditions for a more generative conversation. Balancing the need for input with the need for questions and exploration. The first part of the session was mainly input from Angela Pedder and clinicians on what the new model of care will mean for individuals. Members across the three committees listened to understand the objectives and potential of the new model of care. The second part of the meeting involved table discussions with everyone present to conduct a SWOT analysis where members were able to voice the positives and negatives that they had heard about the system. This part of the session in turn also involved listening, so clinicians could hear first-hand what the concerns of the members of pubic were. The final part of the session involved a feedback summary on the strengths, weaknesses, opportunities and threats that were discussed. The session concluded with a question and answer session to enable any outstanding questions or points to be discussed.

2. What is the 'new model of care' and the evidence base?

2.1 The model of care builds upon many aspects of service planning and delivery that have been developed over time. The 'Success Regime' was invoked to work with the North, East, West (NEW) Devon CCG, along with two other areas in the Country, to change the trajectory of spending. Part of this support requires a credible plan to match demand with allocated resources. This does not cover the area of South Devon and Torbay CCG but crucially the STP does. This means that preparatory work for the NEW Devon CCG under the auspices of the Success Regime will be included in the final plan which will also include South Devon and Torbay. The STP builds on the work of the CCGs and case for change for each area; it sets out how local services will evolve and become clinically and financially sustainable in the next 5 years.

2.2 The STP will provide a framework. It details the principles and strategy which will then be applied across Devon. This has been developed over the summer with more than 80 clinicians and social care staff using feedback from previous public and patient engagement work. The result will be a shared view of how to meet the health and care needs of our communities.

2.3 There is compelling evidence that current ways of delivering care harm patients and wastes money. This is a consequence of failing to intervene early to help patients remain at home or return home from hospital as early as possible. The long term impact of this is significant, to both individuals and the wider health and social care system.

2.4 Staying any longer than necessary in hospital causes harm to patients – muscle function reduction, reduced independence & risk of infection. It particularly affects people who are frail and people who have dementia:

Frailty and Hospitalisation	Dementia
• Frailty is a heath condition related to the ageing process in which multiple body systems gradually lose their in-built reserves. • Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years • Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, e.g. an infection or new medication. • For older people in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. • Older people can quickly lose mobility and the ability to do everyday tasks such as bathing and dressing; loss of muscle strength is up to 5% per day • Prolonged hospital stays increase the risk acquiring infections or other avoidable complications	• Dementia is a common in older people admitted to hospital - around 42% of older patients in hospital have some degree of dementia. • People with dementia face additional risks through prolonged admission, over and above those posed to frail and elderly patients • The combination of a physical illness and a change in environment can be very distressing and confusing for the patient • People with dementia may have difficulty communicating their needs • In the hospital setting there is a high prevalence of delirium (66%) and also of other psychological symptoms: depression (34%), anxiety (35%), delusions (11%) and hallucinations (15%). • The impact of admission to hospital on someone with dementia may not be reversible, and the level of care they need may be permanently increased as a consequence

2.5 To build a picture of the usage of hospital beds in Devon, Public Health Devon undertakes an Acuity Audit. This is a measure of the use of beds on a particular day. Audits were carried out by Public Health at the Devon PCT in 2010, 2011 and Devon Public Health in 2015. The results show that approximately 40% of people in a community hospital bed have no medical need to be there. This means that they are receiving care that they do not need, and in the worst case scenario the stay itself could be harmful to their health.

The model of care

⇒ Comprehensive assessment to identify and support those most at risk of being admitted to hospital in an emergency

⇒ Single point of access and rapid response service - front and back end of the pathway - admission avoidance and expedited discharge

⇒ Building on what is already taking place; each intervention is an extension of work that is already happening in parts of Devon

⇒ Changing how we think and act - changes in system & process only part of the change – 'doing the same, better'.

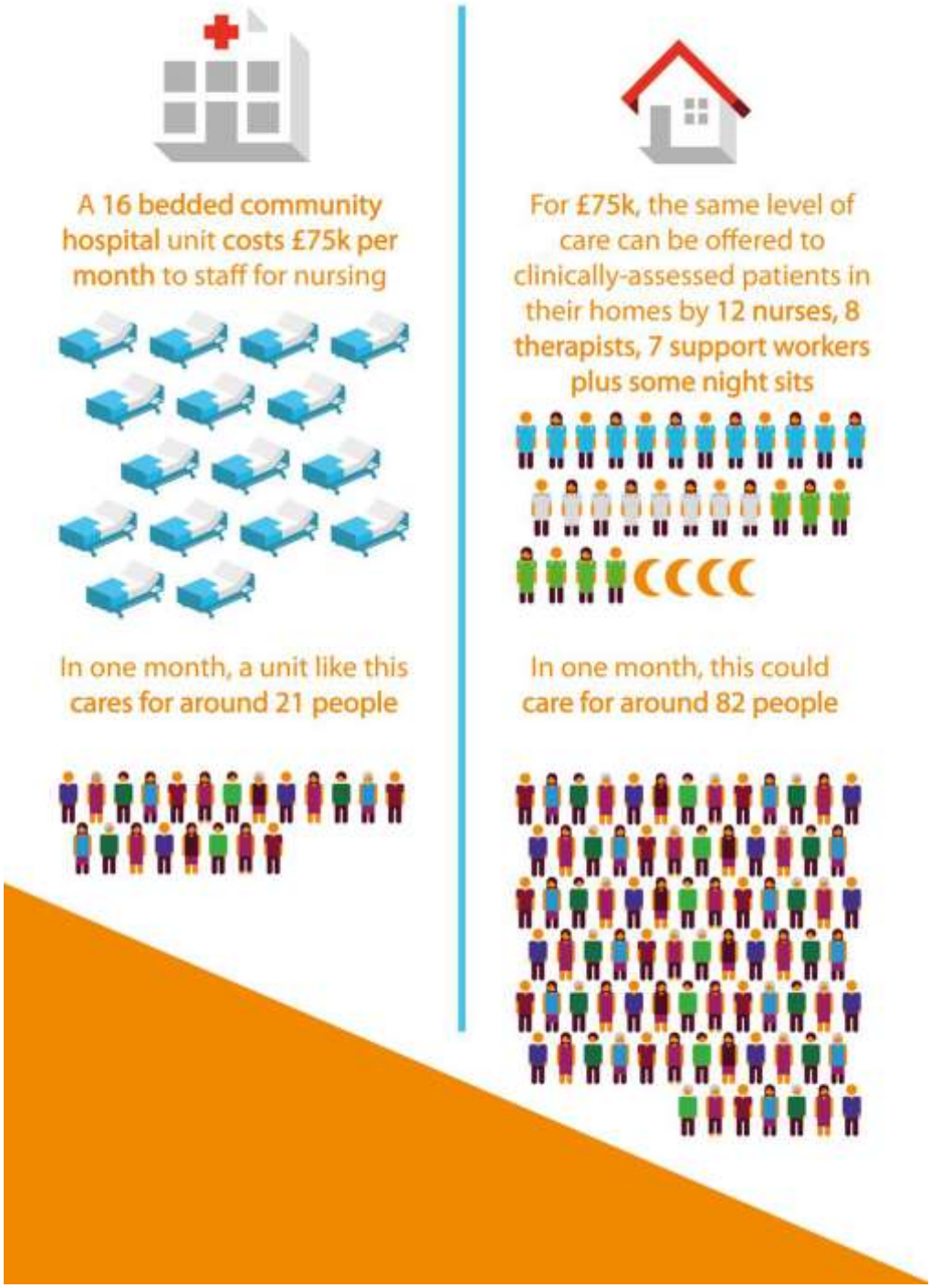
⇒ Leading to changing the focus to prevention, population health & wellbeing. New focus & roles that span health, care and rehabilitation = 'doing things differently'.

⇒ Trust, mutual understanding of risk and ability to share information are essential for successful integration.

2.6 The model of care is built upon the premise that people should be treated in their own homes where ever possible and that conditions that had previously required hospitalisation may no longer need it, or may not need it for as long. To achieve this change in culture, organisations will need to work together beyond boundaries. Culture in organisations and in society in general will need to be challenged. The spotlight review was informed that the proposed model addresses the issue of unnecessary and harmful hospital stays for the frail, elderly and those with dementia. It is based on three key interventions

Comprehensive Assessment	Single point of access	Rapid response
• Identifies people who are frail or becoming frail and more likely to be admitted to hospital • Puts plans in place that help people to be supported and remain well at home • Assessors act as 'community connectors' to support resilient communities	• Makes organising care at home as easy as care in hospital - and 24/7 • Referral can be made by any care service - with a clinical conversation based on patient need • A home-based 'first responder' service available within 2 hours to help support people to stay at home	• Multi-disciplinary team to respond to the needs of people at home and in residential and nursing homes • An initial assessment of need undertaken and a package of care at home applied • Rapid Response Team has access to additional capability and input - including through the acute sector

2.7 The model also enables improved use of resource by transferring resource and workforce from the provision of community hospital beds to the provision of enhanced home based care services more people can be supported. The case for the model of care is illustrated below.


A 16 bedded community hospital unit costs £75k per month to staff for nursing
In one month, a unit like this cares for around 21 people
For £75k, the same level of care can be offered to clinically-assessed patients in their homes by 12 nurses, 8 therapists, 7 support workers plus some night sits
In one month, this could care for around 82 people

3. Strengths/Weaknesses/Opportunities/Threats

3.1 In the spotlight review the general tenor was one of support for the theoretical model. Members welcomed person-centred-care which was individually tailored for the individual. However they did have concerns over how this was going to be achieved in every case across Devon in such a short timescale. The discussions in the spotlight review are represented over the page on the SWOT table. Whilst the SWOT tool gave an accessible mechanism for discussion with the nature of complex change there were, unsurprisingly, several issues that demand more discussion and explanation. These are detailed below.

3.2 Funding was raised as an issue across the session. This was in several parts. The initial driver for change was funding and sustainability concerns. Concerns were voiced about whether the new model of care could actually deliver the scale of changes required. The issue of transition funding was also raised. The spotlight review was informed that the Success Regime has already been able to agree a higher deficit total that is acceptable to Central Government. This is £50 million bigger than Devon would otherwise be able to have. Whilst this is still in the form of borrowing, it does provide liquidity and transition funding.

3.3 Members felt that in general the model de-medicalised treatment and viewed people as people. This heralds a culture change from 'what is the matter with me' to 'what matters to me'. The approach was also extended to thinking about how people are situated in their community against the backdrop of a strong prevention agenda. There is a future for social prescribing further to enable independence and community level interventions that make a difference to individuals.

3.4 The governance and the pace of change were both mentioned more than once in conversations. The answer was that the architecture will be developed as the process develops, that it is important to get the service right first then work on the structure. That releasing the resources first in a phased programme is the way forward. Some of these changes are already in place for example in Torbay, and some are yet to be developed. The model recognises that outcomes for people are the same, but population needs may be different.

3.5 Property ownership and disposal is a complex issue that has recently come to the fore. Questions over who owns what building and what might happen if the buildings are deemed to be surplus to requirements is a thorny issue. The estates strategy that is being prepared will be something that scrutiny takes an interest in. In the meantime understanding the precise ownership arrangements for each hospital may be very useful.

3.6 Several agencies working across traditional organisational boundaries for the best outcomes for a patient is going to be challenging. For a start the professional languages of social care when compared to the NHS are markedly different. Blending teams may mean that one skilled person comes to visit and takes account of all the care, rather than several specialists doing the same on a number of visits. Lone working might be a concern, yet currently there are eleven thousand care workers who currently visit people's homes on their own. In complex cases there are provisions for double handed care, but this is very much done on a case-by – case basis.

Strengths

- **Better outcomes for people.**
- **Value for money** for tax payer.
- **Patient centred approach** with a single point of access, considering the family with wrap-around services and a holistic approach.
- Potential **integration of Health and Social Care.**
- **Reduce pressure** on planned hospital treatments.

Weaknesses

- **Workforce**, are there enough staff and how will we recruit?
- Need to talk about **end of life care.**
- Current **capacity in nursing homes,** particularly for people with dementia.
- **Different agencies**: adult social care NHS commissioners/providers might mean that people fall between the gaps:
  - not integrated budget
  - not integrated technology
  - all agencies need culture change
- **Discharge** has been weak.
- Where is provision for **mental health?**

Opportunities

- Enhanced community role in wellbeing leading to more **resilient communities .**
- Act as a catalyst for **strong local leadership.**
- **Tackle health inequalities** by offering a uniform model of care.
- Using **councillors as ambassadors for change.**
- Focus effort on keeping people well and **prevention.**
- **Plan for the future workforce,** building on higher education offer in the region and cross skilling workforce.
- **Improve public health** across the life course to support self-directed care.

Threats

- **Rurality** and achieving the 2 hour response time.
- **How future-proof is the model** with further funding challenges, a continued increase in the age of the population and the complexity of conditions and further closure of local services like pharmacies?
- **Communication and understanding with the public**. There is great distrust around NHS change. There needs to be a change in attitude.
- **Implementation**: It is essential that interventions are timely. The new model will need to resolve delays to personal budgets.

4. Conclusion

Members In the room agreed that hard and difficult conversations need to happen. Change in the NHS is emotive and presents challenges for all who come into contact with the system. Fundamentally there was support for the model of care, for better outcomes for patients and for more intensive rehabilitation. However there are enduring concerns over exactly what this will mean in each location and whether the additional services and staff will be in place to make this happen in the short term.

One of the most insightful conclusions to come out of the meeting was the need for Councillors to be empowered with information in order to become ambassadors for change. This will require members to be well briefed and included as developments unfold. The three Scrutiny Committees will have an ongoing role as development of the STP continues and individual areas consult on changes. The three committees are the upper tier authorities and therefore will be statutory consultees on major change to the NHS. They will also have a role in ensuring that the voice of the public continues to be heard.

From now each authority's Scrutiny Committee can consider how they feed this collective piece of work into their scrutiny deliberations in the future.

5. Attendees

Members

The spotlight review was chaired by Cllr Richard Westlake with the following Members of the three Councils:

NAME	COUNCIL	ROLE
Cllr Frank Biederman	Devon	People's Scrutiny
Cllr Jerry Brook	Devon	Health Scrutiny
Cllr Rufus Gilbert	Devon	Health Scrutiny
Cllr Brian Greenslade	Devon	Health Scrutiny
Cllr Sara Randall Johnson	Devon	People's Scrutiny
Cllr Andy Boyd	Devon	People's Scrutiny
Cllr Margaret Squires	Devon	People's Scrutiny
Cllr Richard Westlake	Devon	Health Scrutiny
Cllr Claire Wright	Devon	Health Scrutiny
Cllr Debo Sellis	Devon	Health Scrutiny
Cllr Barbara Cunningham	Torbay	Community Services/STP Review Panel
Cllr Cindy Stocks	Torbay	Community Services/STP Review Panel
Cllr Neil Bent	Torbay	Community Services/STP Review Panel
Cllr Jane Barnby	Torbay	Community Services/STP Review

		Panel
Cllr Jackie Stockman	Torbay	Community Services/STP Review Panel
Cllr Nick Bye	Torbay	Community Services/STP Review Panel
Cllr Mary Aspinall	Plymouth	Chair of Wellbeing Scrutiny
Cllr David James	Plymouth	Vice Chair of Wellbeing Scrutiny

Witnesses

The Spotlight review was well attended with officers from across Devon from Councils, the CCGs and the Success Regime/STP team. The Members of the spotlight review would like to express sincere thanks to the following for their involvement and the information that they have shared.

Officer	Organisation	Role
Angela Pedder	Your Future Care (Success Regime) & Devon STP	Lead Chief Executive
Dr. Phil Hughes	Plymouth Hospitals NHS Trusts/ Devon STP	Medical Director
Dr. Simon Kerr	NEW Devon CCG	Eastern Locality Vice Chair and GP Lead
Rob Sainsbury	Northern Devon Hospital Trust	Executive Operations Director
Jenny McNeil	NEW Devon CCG	Associate
Jo Andrews	Carnall Farrar	Principal
Teresa Widdecombe	Your Future Care (Success Regime) & Devon STP	Programme Manager
Dr David Greenwell	South Devon & Torbay CCG	Chair of Community Services Transformation Group
Rebecca Foweraker	South Devon & Torbay CCG	Head of Commissioning for Integration
Tim Golby	Devon County Council	Head of Adult Commissioning and Health
Fran Mason	Torbay Council	Head of Partnership, People's & Housing

Special Mention must be made of Kate Spencer and Ross Jago, Scrutiny Officers from Torbay and Plymouth respectively, for all of their assistance in co-ordinating and carrying out this piece of work.

6. Contact

For all enquiries about this report or its contents please contact

Camilla de Bernhardt Lane cam.debernhardtlane@devon.gov.uk

Report to Devon Health and Wellbeing Scrutiny Committee
8th November 2016
Wider Devon Sustainability and Transformation Plan (STP)

Recommendation

That Devon Health and Wellbeing Scrutiny Committee:

- Notes the latest position on the Wider Devon Sustainability and Transformation Plan including the timeline and next steps
- Considers how the Committee can best be engaged in the Sustainability and Transformation Plan going forward

1. Purpose

The Devon Sustainability and Transformation Plan (STP) is a plan that covers the whole of wider Devon, including its three local authorities and two clinical commissioning group areas. Wider Devon has a resident population of around 1,160,000 with just over half living in urban communities and just under half living in rural communities. The STP is the local plan to achieve the NHS 'Five Year Forward View' published in October 2014[1] and to address the challenges faced locally particularly those set out in the Case for Change[2].

The STP is designed to provide the overarching strategic framework within which people residing in wider Devon will experience safe, sustainable and integrated local support by 2021. At the same time it is focused on closing the financial gap that exists, recognising that doing nothing is not an option and transformational change is essential to address the significant challenges faced by the local system.

The partner organisations within the wider Devon footprint working together in relation to the STP are: NEW Devon CCG, South Devon and Torbay CCG, Plymouth Hospitals NHS Trust, Royal Devon and Exeter NHS Foundation Trust, Northern Devon Healthcare NHS Trust, Torbay and South Devon NHS Foundation Trust, South West Ambulance Service Trust, Devon Partnership NHS Trust, NHS England, Circa 160 GP practices, Virgin Care, Devon County Council, Plymouth City Council, Torbay Council, Livewell Southwest CIC, Devon

[1]Five Year Forward View https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2]Success Regime Case for Change http://www.newdevonccg.nhs.uk/about-us/your-future-care/success-regime/case-for-change/101857

Doctors, Healthwatch (Devon, Plymouth and Torbay) and Care UK and Voluntary and Community Sector Organisations.

Devon Health and Wellbeing Scrutiny Committee has previously received the Success Regime Case for Change and reports on the development of the Sustainability and Transformation Plan. A draft plan was submitted to NHS England in June with positive feedback. This draft has now been updated and once NHS England approval is received the final STP will be provided to Devon Health and Wellbeing Scrutiny Committee and made available to the public. In the meantime this paper is designed to provide the Committee with an update on progress with the STP and to set out the next steps.

2. STP overview

The STP is built around an aspiration to achieve, by 2021, a fully aligned sense of place, linking the benefits of health, education, housing and employment to economic and social wellbeing for communities through joint working of statutory partners and the voluntary and charitable sectors. In this context the partner organisations involved in the STP are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations served.

In recognition of the growing physical and mental health needs of the population the STP sets out to achieve the 'triple aim' of the Five Year Forward View - to improve population health and wellbeing, experience of care and cost effectiveness per head of population. It also sets out to address key challenges as summarised below.

- People are living longer and will require more support from the health and care system. In excess of 280,000 local people, including 13,000 children, are living with one or more long term condition
- The system needs to respond better to the high levels of need and complexity in some parts of the population
- Some services such as stroke, paediatrics and maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered across the system
- There is a difference of 15 years in life expectancy across wider Devon and differences in health outcomes – or 'health inequalities' – between some areas, particularly Plymouth
- Spending per person on health and social care differs markedly between the locality areas and is 10% less in the most deprived areas
- Mental health services are not as accessible and available as they need to be, driving people to access other forms of care with limited value from the intervention received. People with a mental health condition have poorer health outcomes than other groups
- There is an over reliance on bed based care - every day over 600 people in Wider Devon are medically fit to leave hospital but cannot for a variety of reasons
- The care home sector is struggling to meet increasing demand and complexity of need
- Almost a quarter of local GPs plan to leave the NHS in 5 years and there are significant pressures on primary care services. Some other services are particularly fragile due to high levels of consultant, nursing, social work or therapy vacancies
- Local health and social care services are under severe financial pressure, and health & social care services are likely to be £557m in deficit in 2020/21 if nothing changes.

The key focus of the STP will be on activities that will make the biggest difference to population health and financial recovery. Seven priorities have been identified. These priorities are:

- Prevention
- Integrated care
- Primary care
- Mental health
- Children and young people
- Acute hospital and specialist services
- Productivity

Once the STP is finalised the transformation programme will include more detailed work and planning around each of these areas. Already there has been progress in development of a more integrated care model and planning for the acute hospital and specialist services review is well underway.

3. Next steps

Already there is work underway in 2016/17 on early improvements and efficiencies that can be made and this has previously been reported to the Committee. The NEW Devon model of care work as described in 'Your future care' is currently included in the consultation and is presented as an item on the 8th November 2016 Committee agenda. As previously reported to the Committee South Devon and Torbay CCG are also currently consulting. The development of the previously discussed acute and specialist services work programme is nearing completion and details will be made available shortly.

In relation to the STP document, this will be finalised and published in November 2016. In providing a framework for a programme of transformation it is essential that there is ongoing dialogue with patients, volunteers, carers, clinicians and other staff, public, local voluntary and community sector, local authorities and political representatives. This dialogue will relate to the whole STP contents and will also include targeted involvement and consultation where applicable.

It is important to note that the STP is designed to build on and expedite progress with current plans as well as introducing new areas of focus. Work will also advance on the detailed planning in relation to each of the seven STP priorities listed in section 2 of this paper. In addition to noting the latest position on the Wider Devon STP, it would be useful to consider with the Scrutiny Committee how the Committee and other stakeholders and public can best be engaged in the STP going forward including a further report to Committee on 19th January 2017.

Report prepared by: Jenny McNeill, Associate, NEW Devon CCG
Wider Devon STP Lead: Angela Pedder, Chief Executive

Devon Health and Wellbeing Scrutiny Committee Meeting

8th November 2016

Report to Devon Health and Wellbeing Scrutiny Committee

8th November 2016

Your Future Care Consultation

Recommendation

In line with the Local Authority Scrutiny Regulations (2013), Devon Health and Wellbeing Scrutiny Committee is invited to:

- Acknowledge the consultation process and encourage public participation
- Respond to the consultation as a key stakeholder and statutory consultee
- Provide views of the new model of care and engage in its further development

1. Purpose

As reported to the Devon Health and Wellbeing Committee in September 2016, 'Your Future Care' sets out an integrated model of care that is designed to strengthen prevention and out of hospital care and to shift from a reactive to a more pro-active approach to community based service delivery. As such the model of care builds on the agreed priorities of the Clinical Commissioning Group's Transforming Community Services Programme, the NEW Devon Success Regime Case for Change and the developing wider Devon Sustainability and Transformation Plan.

'Your Future Care' does propose options for service reconfiguration and public consultation commenced on 7th October 2016. This paper, which is provided for consideration by Devon Health and Wellbeing Scrutiny Committee, describes the context, content and process of this consultation and is accompanied by:

- 'Your Future Care' Consultation Document and Response form. The document sets out the model of care and the proposed options community hospital inpatient reconfiguration in Eastern Devon (appendix 1a and 1b).

- The Consultation Plan which details the consultation approach, process and timetable with links to further information associated with the consultation and the programme of meetings and events (appendix 2).

2. Proposals and process

2.1 Consultation Proposals

The Consultation Document (appendix 1a) explains that the services currently in Devon cannot be sustained clinically or financially and that it is necessary to secure a health and care system capable of meeting the changing needs of the population. It also sets out the need to reduce current reliance on bed based care and achieve a model of care that enables people to be, and stay, at home wherever possible with appropriate support unless there is a clinical need to be in hospital. This model is expected to bring the following benefits:

- improved patient experience
- improved outcomes of care
- improved health and wellbeing
- improved staff experience

The changes proposed are designed to achieve more integrated and consistent services in Northern, Eastern and Western Devon through:

- Comprehensive assessment to identify people who are frail, or pre-frail and therefore at risk of admission to hospital and put in place a care plan that outlines potential avenues for escalating care when required.
- Single point of access through one phone number to make getting additional support as easy as possible, when it is needed urgently and which is connected to a first responder and rapid response service.
- Rapid response service providing additional support at home to avoid admission to hospital or put arrangements in place to make it safer to leave hospital.

The intention is to strengthen community services and also to unlock wider change in acute healthcare, address inequalities, and better meet the needs of diverse communities. The consultation document proposes changes in the number and configuration of community hospital inpatient beds in Eastern Devon with four configuration options, and a preferred option (Option A):

- Option A: 32 beds at Tiverton, 24 beds at Seaton and 16 beds at Exmouth
- Option B: 32 beds at Tiverton, 24 beds at Sidmouth and 16 beds at Exmouth
- Option C: 32 beds at Tiverton, 24 beds at Seaton and 16 beds in Exeter
- Option D: 32 beds at Tiverton, 24 beds at Sidmouth and 16 beds at Exeter

In addition to requesting views in relation to the options presented, the consultation also invites alternative proposals. It is important that this consultation prompts discussion and debate to inform decision making to achieve joined up services to support individual patients, meet needs and promote independence, health and wellbeing.

2.2 Consultation Plan

The public consultation is from 7th October 2016 until 6th January 2017, a total of 13 weeks – effectively 12 weeks allowing for the Christmas and New Year Bank Holidays. The consultation aims to obtain the views of individual patients and members of the public; interest or representative groups; key stakeholders; clinicians and staff. It is designed to take account of the rurality of Devon as well as the urban considerations, and adopts a range of approaches to consult with those with protected characteristics as described in the Public Sector Equality Duty.

The Consultation Plan (appendix 2) details the distribution of key documents and provides further information on the consultation and the CCG website hosts all consultation material, which can be downloaded, and also enables people to request paper copies. The Consultation Plan indicates targeting information on the elderly frail, including those in late middle age, as they are likely to be affected most by the proposals.

The main elements of the consultation are summarised below:

a. <u>Consultation materials</u>

The key consultation materials are:

- 'Your Future Care' Consultation Document (both a full document and shorter summary document are available)
- 'Your Future Care' Consultation Response Form (included in the Consultation Document and available on the web). This can be completed online, posted or emailed.

There is also a wide range of supporting information including the technical Pre-Consultation Business Case which is available on the CCG website or on request. Copies of the full consultation document, including the response form and freepost envelope for return, have been sent to:

- town and district council offices
- community hospitals and Leagues of Friends
- GP practices
- Healthwatch Devon and their hard to reach delivery partners, including Citizens Advice Bureau
- leisure centres
- memory cafes
- libraries
- MPs
- local NHS providers

The summary document is being distributed to all of the above, plus the following:

- residential and nursing homes
- pharmacies
- churches and church halls

- garden centres
- British Legion offices
- hairdressers
- community transport providers

b. Consultation meetings

These consist of consultation events and public meetings. The first phase is in Eastern Locality. These events are being advertised widely, including in local media, through stakeholder newsletters and key stakeholder contacts and the programme is in appendix 2. Steps have been taken to arrange the meetings in venues are accessible and to schedule the meeting times to encourage a wide range of participation.

In addition CCG Community (lay) Representatives are working to ensure local communities are aware of the opportunities to be involved. There has been contact with local parish council clerks to ask how best to communicate with different local communities and with Healthwatch Devon, patient representatives, town councils and the local media to ensure events are well publicised.

In addition, 'Pop Ins' have been arranged as a means of face to face engagement with local communities that will help capture feedback from people who may not be able to access the consultation events, public meetings or the document through other routes. 'Pop Ins' consist of a member of staff visiting various locations and speaking to members of the public about the consultation and encouraging them to complete the response form. The locations targeted are primarily in the eastern locality commencing 24th October 2016 and continuing throughout the consultation. The populations specifically aimed at are the frail elderly.

To build on clinical and staff involvement that took place in the pre-consultation period, staff are invited to participate in the consultation and a range of approaches are being adopted to ensure staff have an opportunity to have their say.

c. CCG Website

All consultation materials are available on the CCG website. In addition there are newsletters, frequently asked questions, videos, copies of press releases, links to publications and sources of evidence, details of meetings and events.

Consultation responses will be received by the Consultation Response Unit (CRU) within the CCG. People may also ask the CRU to fill in the details on their behalf.

Consultation response unit: (9am-6pm Mon to Friday) 01392 267 642

Freepost YOUR FUTURE CARE (no stamp required)

EMAIL: d-ccg.yourfuturecare@nhs.net

Website: www.newdevonccg.nhs.uk/about-us/your-future-care/102019

2.3 Consultation Process

The consultation has been planned in accordance with the CCG's responsibilities and duties as set out in 'Planning, Assuring and Delivering Service Change for Patients'. In this context, prior to launching the consultation, the content and process was subject to the NHS England assurance which approved commencement of the consultation. This assurance is an important aspect of ensuring the consultation meets the necessary statutory and process requirements and will be ongoing during the consultation and through to decision making.

Key guidance has also underpinned the start of consultation including Cabinet Office Consultation Guidance, the Government 4 tests for major service change, as well as the NHS England Guidance above. As for the Gunning Principles (2001) the process is designed to provide that:

- consultation takes place when proposals are still at a formative stage
- there are sufficient reasons for proposals to permit 'intelligent consideration'
- there is adequate time for consideration and response
- consultation responses are conscientiously taken into account

Reporting on the consultation will take place following the end of consultation period. However, regular reports will be posted on the CCG's website. The CCG and NEW Devon Success Regime expect to be in a position to present to Devon Health and Wellbeing Scrutiny Committee an overview of themes from the responses at the Committee meeting on 19th January 2017, recognising that the papers are due to be submitted to Committee approximately one week after the close of consultation. The full consultation report will be available within 8 weeks of consultation close.

3. Decision making and next steps

3.1 Decision making

The decision making body in relation to this consultation is NEW Devon Clinical Commissioning Group. The Governing Body decided to proceed to consultation at its meeting in public on 28th September 2016. In making that decision the Governing Body took into account: information and evidence supplied by the NEW Devon Success Regime support team plus a range internal and external assurance processes in relation to readiness to proceed to consultation.

Following close of consultation the Consultation Report will be prepared setting out the views and learning from the consultation. The next step will be to refresh the Pre-Consultation Business Case in the light of: the outcomes of consultation; ongoing development of the model of care; and impact assessments including

quality, equality and finance. This will then be prepared as a Decision Making Business Case and will inform the final proposal.

As with the process to commence consultation, the Decision Making Business Case will be subject to internal and external assurance in advance of the CCG Governing Body being asked early in 2017 to decide on the final proposal and agree a process and milestones for implementation. As indicated in the Consultation Document any implementation will be subject to a series of clinically led tests as part of a Gateway Process to confirm clinical confidence of readiness to implement.

3.2 Next steps

The CCG and Success Regime Team welcomed the opportunity to participate in the joint Devon, Plymouth and Torbay Spotlight review of the model of care which was led and hosted by Devon Health and Wellbeing Scrutiny Committee on 5th October and is due to be reported on 8th November 2016. The engagement of the three local authorities and structure of the review brought key insights that will help strengthen the model of care and, whilst recognising the challenges and concerns about what this will mean in each location, there was support for the model and better outcomes for patients.

A further Scrutiny Spotlight review is planned in relation to Quality and Performance in November 2016 bringing the opportunity for learning from Scrutiny reviews to inform the next phases of development and decision making. The CCG and Success Regime would welcome further opportunities to engage with Councillors in service change through such joint and individual Scrutiny Committee reviews and would welcome the opportunity to discuss with Scrutiny the potential of an event inviting wider local Council input during the course of Consultation.

Specifically through this paper, the CCG and NEW Devon Success Regime wish to inform the Devon Health and Wellbeing Scrutiny Committee of the consultation process, to consult with the Committee in relation to proposals and options in the 'Your Future Care' consultation, and invite views on the new model of care to achieve clinically and financially sustainable services for the population. This is as set out in the recommendation that Devon Health and Wellbeing Scrutiny Committee is invited to:

- Acknowledge the consultation process and encourage public participation
- Respond to the consultation as a key stakeholder and statutory consultee
- Provide views of the new model of care and engage in its further development

The CCG then proposes to report the themes of Consultation to Committee on 19th January 2017, with a fuller report to Committee on 2nd March 2017.

4. Conclusion

As stated in the consultation document this consultation will prompt difficult discussion and debate. There will be tough choices to make if we are to ensure sustainability of local health and care services. The Council is familiar with such decisions and although there will be wide ranging views on the consultation

proposals, the CCG would welcome Scrutiny support in encouraging participation in the consultation and generating debate on how best to deliver effective change.

5. Appendices

- Appendix 1a: 'Your Future Care' Consultation Document
- Appendix 1b: 'Your Future Care' Consultation response form
- Appendix 2: 'Your Future Care' Consultation plan

Paper prepared by: Jenny McNeill, Associate, NEW Devon CCG

CCG Executive Lead: Laura Nicholas, Director of Strategy, NEW Devon CCG

YOUR FUTURE CARE

Consultation Document

Consultation from 7 October 2016 to 6 January 2017

Your future care

Contents

Executive summary

What this document is for

Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) is accountable for the commissioning of healthcare services to meet the needs of the population of about 900,000 people in the Northern, Eastern and Western parts of Devon (named localities in this document).

We are responsible for delivering care which meets the needs of all residents and for doing so in a way that makes best use of taxpayer funding. NEW Devon is not responsible for South Devon and Torbay which has its own Clinical Commissioning Group (CCG).

This document sets out proposals to improve your future care in Northern, Eastern and Western Devon by providing more care in people's homes and avoiding hospital admissions where possible. We want to implement a consistent model of community services across NEW Devon, one which is based on the principles and priorities identified in earlier engagement and consultation with the public and clinicians.

This previous consultation led the CCG to develop six strategic principles to guide the commissioning intentions for community services in future.

They are that our community services should:

- Help people to stay well.
- Integrate care.
- Personalise support.
- Coordinate pathways.
- Think carer think family.
- Home as the first choice.

Doctors, nurses, therapists and social care professionals from across our health and social care system have worked together to develop proposals to design a model of care which meets all these principles.

To achieve this we need to shift our resources and focus from hospital beds to the care surrounding our patients in their own homes. This consultation is therefore about how we decide the location of fewer community hospital inpatient beds in Eastern Devon whilst giving people the reassurance as to the improved care they can expect instead in their own homes.

Local health and social care organisations are facing a financial shortfall in 2015/16 of £122m (4% of funding), rising to £384m (14% of funding) in 2020/21 if nothing changes.

These proposals have been expressed as four options, explained in full from page 34 of this document and summarised below.

Consultation options

In addition to the consistent and enhanced provision of community health and social care delivered in people's homes, the services will be supported by consolidating community inpatient beds in the following possible configurations, subject to consultation:

The preferred option is A, as this combination results in the smallest changes in travel time and has greatest whole system impact.

Honiton Hospital and Okehampton Hospital do not appear in any of the shortlisted options. Subject to consultation, the proposal would mean that there would be no inpatient beds on either of these sites and the new model of care would be implemented.

Option A

Beds at:	**Tiverton**	**32**
	Seaton	**24**
	Exmouth	**16**

Option B

Beds at:	**Tiverton**	**32**
	Sidmouth	**24**
	Exmouth	**16**

Option C

Beds at:	**Tiverton**	**32**
	Seaton	**24**
	Exeter	**16**

Option D

Beds at:	**Tiverton**	**32**
	Sidmouth	**24**
	Exeter	**16**

Scope of consultation

The consultation will run over 13 weeks from 7 October 2016 to 6 January 2017. If you would like additional response forms please contact us at the details below.

We are asking for your views on whether you think the proposed options will deliver the model of integrated care described over the following pages, and on the best locations for community beds in Eastern Devon.

This document has been widely distributed. If you would like more information, including the technical Pre-Consultation Business Case (PCBC), you can find it on our website at: **www.newdevonccg.nhs.uk/about-us/your-future-care/102019**. You can also order a copy from our Freepost address or phone number, which are both shown on this page.

Please read the consultation document all the way through and then, on the response form provided, answer the questions we have asked.

You can fill in your answers on the printed response form and post it to our Freepost address: **Freepost YOUR FUTURE CARE**. This must be written exactly as it is shown above, including capital letters where indicated, and you will not need a stamp.

Or, you can fill in an electronic version of the response form online on our website: **www.newdevonccg.nhs.uk/about-us/your-future-care/102019**. We must receive your response form no later than **6 January 2017**.

Contact us

Telephone: 01392 267 642

E-Mail: d-ccg.YourFutureCare@nhs.net

Write: Freepost YOUR FUTURE CARE (no stamp required)

Thank you for your interest in this important consultation.

This document is also available in other languages, in large print and in audio format. Please do not hesitate to call us on **01392 267 680** or email **d-ccg.YourFutureCare@nhs.net** if you would like to receive it in one of these formats.

Polish

Dokument ten dostępny jest również w innych językach, dużym drukiem i w formacie audio. Jeśli chcą Państwo otrzymać ten dokument w jednym z tych formatów, prosimy o bezzwłoczny kontakt pod numer **01392 267 680**.

Lithuanian

Šį dokumentą galite gauti ir su vertimu į kitas kalbas, dideliu šriftu bei garsiniu formatu. Prašome nedvejodami kreiptis į mus telefonu **01392 267 680** norėdami dokumentą gauti vienu iš šių formatų.

Chinese

这份文件还提供其他的语言版本，大型字和音频格式。如果你需要，请不要犹豫联系我们，电话是 **01392 267 680**.

Sorani Kurdish

گەورەو بە شێوازی دەنگیش. تکایە دوودڵ مەڵە پێوەندیکردن بە پێمانەوە بە ژمارەی **01392 267 680** ئەگەر خوازیار بیت بە.
یەکێک لەم شێوازانە بە دەستت بگات

Bengali

এই ডকুমেন্টটি অন্যান্য ভাষায়, বৃহ মুদ্রণে এবং অডিও ফরম্যাটে পাওয়া যায়। এসব ফরম্যাটের কোন একটি পতে চাইলে **01392 267 680** ননম্বরে আমাদের সাথে যোগাযোগ করতে দ্বধিা করবনে না।

Arabic

يمكنكم أيضاً الحصول على هذا المنشور بلغات أخرى أو بكتابة بخط أكبر أو مسجل صوتياً. رجاء عدم التردد في الإتصال بنا على رقم **01392 267 680** وذلك لطلب المنشور بأي شكل من هذه الأشكال.

If you have any complaints about the consultation please contact:
Patient Advice and Complaints Team
NHS Northern Eastern and Western Devon Clinical Commissioning Group
Freepost EX184
County Hall, Topsham Road
Exeter EX2 4QL

Telephone: 01392 267 665 or 0300 123 1672

Text us for a call back: 07789 741 099

Email: pals.devon@nhs.net or complaints devon@nhs.net

Foreword

Angela Pedder OBE
Lead Chief Executive in Northern, Eastern and Western Devon

Dame Ruth Carnall
Independent Chair of the Success Regime

"The changes proposed in this document respond to the description of care members of the public and our clinical and care staff have said they want to have. To sustainably deliver the new service we need to change the current model.

They are part of a wider programme of change that will be necessary to secure a clinically sound and financially sustainable health and care system for Devon."

The changes we propose in this document will prompt difficult discussion and debate. Put simply we cannot carry on as we are. The services we have currently in Devon cannot be sustained and that is not only about money. We must take action now and implement a programme of change to secure a health and care system capable of meeting the changing needs of our population. The problem is ours, must be addressed, and a solution found no matter how difficult that might be.

This consultation focuses on the need to create services in our communities which are fully joined up to support individual patients regardless of whether they live in towns or in isolated rural settings. Services which meet needs and which are effective at promoting the independence and health and wellbeing of our patients. We call this a 'new model of care' but in fact it is a model which already works in parts of Devon but not yet across the whole county for everyone. The changes proposed here are the first part of a wider programme of change that will be necessary to secure a clinically sound and financially sustainable health and care system for Devon. We will be discussing the whole programme over coming months.

Everyone living in Northern, Eastern and Western Devon should be able to access great care. There are examples of excellent practice in many areas but none are universal. The reality of the situation we face is that we do not currently provide an equitable service to people across all our communities. Many of our most vulnerable groups and populations receive lower levels of support.

Staff work hard to deliver care, many working additional hours to sustain services. Our population is ageing and our staff are also getting older.

Staff upon whom we have relied for many years are approaching retirement age and we are experiencing increasing difficulty in recruiting staff to replace them. This increases our reliance on temporary and agency staff which in turn impacts on the quality and continuity of service we can offer. It also increases the cost of our services. All of these factors contribute to the growing problems we are experiencing. We have to find a way to maximise the care we can provide, making the best use of our scarce resources and creating attractive employment opportunities that people will want to take.

During 2014, NEW Devon CCG began an extensive programme of discussion and engagement with people across Devon seeking their views on what was important to them in the design of health care services. Clear messages emerged. People wanted joined up care, which supported and promoted their independence, and was provided as locally as possible. They could describe the frustration and waste that resulted from different parts of the health and social care system operating in silos, and the impact of this on their care. At times when people are at their most vulnerable and most in need of support, our current system requires them to navigate their way through the multiple boundaries that exist between services. Our GPs and other clinical staff also described similar difficulties. This results in delays, multiple assessments, and frequently the only care intervention available is an emergency referral to a hospital due to the lack of a more appropriate, easily accessible alternative service.

This view is supported by the findings of an audit published in October last year which identified over 600 people being cared for in a hospital bed who did not need to be there, but who required a package of support to enable them to return home.

The support required was not available because it was tied up in staffing the very beds people didn't need to be in. Indeed if these resources were not tied up in supporting bed-based services, some people may not have needed to be admitted to hospital in the first place. Being in a hospital bed for longer than necessary causes significant loss of capability. In the elderly this can mean the end of living independently in their own home. It is not safe and it is not effective care to be in hospital unnecessarily and it can be profoundly disabling.

The changes proposed in this document respond to the description of care members of the public and our clinical and care staff have said they want to have. To sustainably deliver the new service we need to change the current model. These proposals have been developed to help build community resilience across Northern, Eastern and Western Devon and provide a platform capable of supporting resilient healthy and economically active communities.

They are a first and crucial step in a bigger picture of change. This work will support the next phase as we develop plans to ensure our acute and specialist services are clinically and financially sustainable. We expect further changes will be important, and where necessary and appropriate will consult on these.

The health service will not be able do this alone and will work in partnership with our local authority, voluntary and charitable sector partners, who have contributed to the development of the model of care we describe in this document.

We look forward to hearing your feedback to this consultation. Thank you in advance for your contributions.

Introduction from locality chairs

As local GPs, we are uniquely and fortunately placed to understand the NHS – the great things it does and its tireless efforts to support people to remain healthy as well as treat them when unwell.

But being on the frontline we also see the challenges, the lack of joined-up services and how this can impact on the lives of those in our care.

This consultation explains proposed changes in how people across Northern, Eastern and Western Devon are cared for. The changes are needed to unlock resources to deliver improved care and to contribute to creating a financially and clinically sustainable health service in Devon.

In many cases the care provided by NHS staff in our area is among the best in the country, often in facilities supported by investment from local communities and Leagues of Friends. But we also regularly see patients that should have received better care. We know we can do more to prevent unnecessary hospital admissions and support a faster return home for our patients.

Patients certainly deserve better. Too many people are currently in hospitals when they don't need to be there. This is at a time when growing evidence suggests that a length of stay in hospital over 10 days can cause some aspects of people's health to deteriorate, particularly in relation to muscle strength, with the risk of loss of mobility leading to increased falls, loss of confidence and independence – and so advancing frailty.

The average length of stay in our community hospitals today is over 23 days[1], and so we risk causing avoidable harm to patients. This is powerful motivation for us to improve the care we commission.

We know that 40% of our community hospital inpatients never get back to their own home. A report by the Alzheimer's Society, published in 2009 and based on the experience of nurses, relatives and carers said the longer people living with dementia in particular were in hospital, the worse the effect on their symptoms – with discharge to a care home or other place of institutional care more likely and the potential for greater use of antipsychotic drugs.

So when patients do return home after a spell in hospital, they often find their confidence and independence has reduced.

Even when they return home, if there are too few services in the community, patients can soon find themselves back in hospital again, deteriorating further in what can all too often become a downward spiral.

Meanwhile a study by the University of Birmingham[2] into the contribution of older people to understanding and preventing avoidable hospital admissions has found that whilst there is evidence of good initiatives to try and divert older people from hospital, the ways into these services were sometimes complicated, for older people and professionals alike.

Health staff surveyed felt that hospital admission was more likely to be avoided if older people had early access to specialist staff who understood the complexity of the health and social problems which older people may experience.

[1] Care Quality Commission – Community Health Inpatient Services (11 September 2014).
[2] 'Who knows best?' Older people's contribution to understanding and preventing avoidable hospital admissions, University of Birmingham, September 2016.

The truth is that there are too few alternatives to bed-based care in the community – and it is this we must change. To do so we need to reduce the number of hospital beds in eastern Devon.

There is a growing and compelling body of evidence that the solution lies in developing community services outside hospital which in turn reduces the numbers of people unnecessarily admitted to a hospital.

This consultation proposes putting in place the right community services for people so that unless there is a clinical need, they do not find themselves in hospital.

The model will enable us to personalise care and pre-empt health crises through proactive care planning and targeted intervention to those most at risk. It will be a more active, rapid but comprehensive multidisciplinary service that gets patients back to the familiarity of their homes and families as soon as possible.

The model (detailed from page 18) will also put us on a more sustainable financial footing. There is a real imperative then to both improve the care of the most vulnerable in our communities and improve the financial stability of the NHS locally.

If we are to really care for the next generations of elderly people – the newly retired, and even those now in middle age, if we are really to create a local health care system which can sustain support to the health needs of the population we are to have in the future – then we must invest in, and redesign, primary and community care.

Throughout our careers as GPs, we have sought to improve the lives of the people we care for. We firmly believe that the model set out in this document will enable us to provide better care that patients deserve right across NEW Devon.

Please have your say.

Dr Tim Burke

Dr Paul Hardy

Dr David Jenner

Dr John Womersley

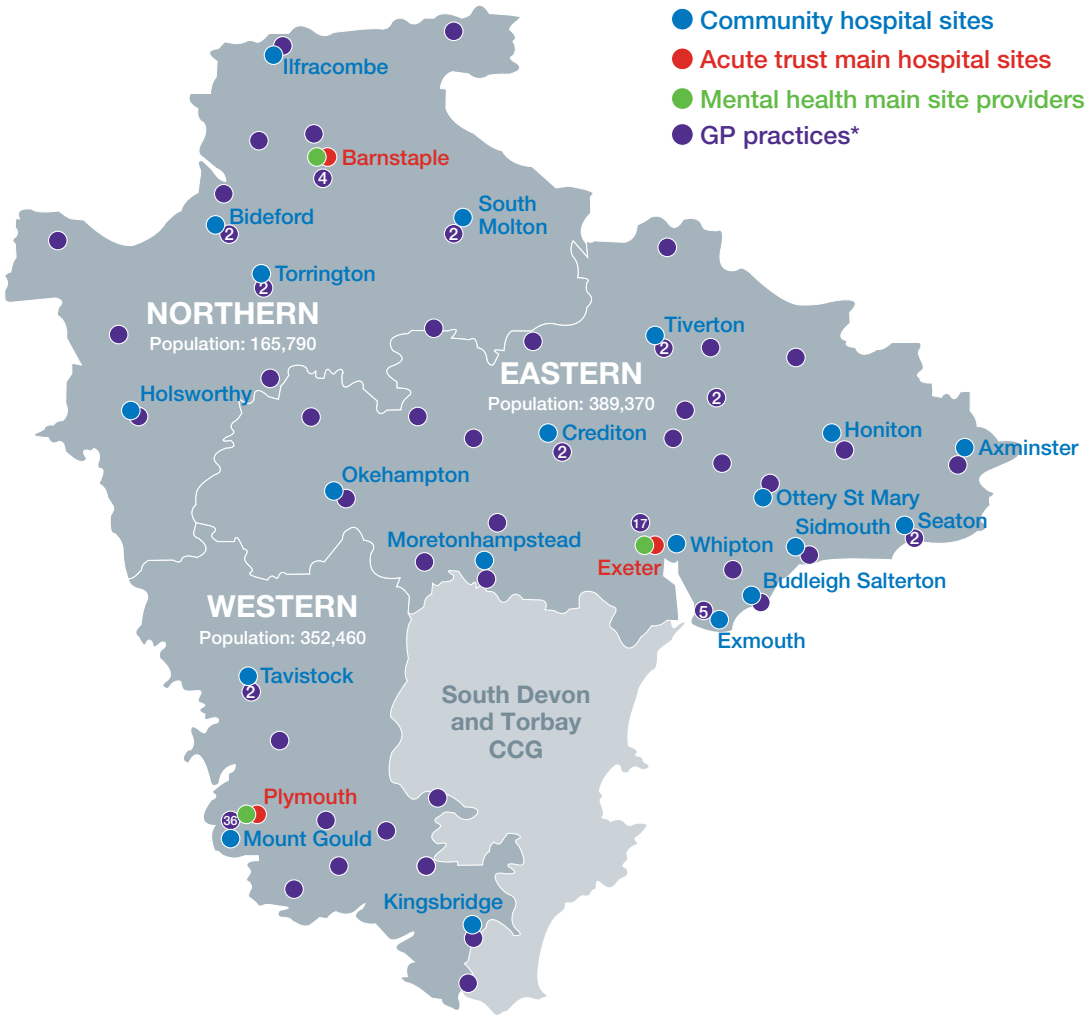
1 Your local NHS

NHS NEW Devon CCG commissions health care for almost 900,000 people in the Northern, Eastern and Western localities of Devon. The three localities were developed to reflect the hospital that patients are predominantly referred to – Royal Devon & Exeter, North Devon District Hospital, and Derriford Hospital in Plymouth. In recent years Okehampton services were run by North Devon Healthcare Trust, as they ran all community services in the Eastern locality until 1 October 2016. The Eastern locality of Devon refers to East Devon, Exeter, Mid Devon and parts of West Devon including Okehampton.

There are many local NHS providers of health care including independent and voluntary sector organisations, GPs, hospitals, community services and mental health services.

These services see many people with 5.5 million GP appointments a year across NEW Devon, 838,000 contacts with community staff and 190,000 people attending one of our three Accident and Emergency (A&E) departments. Health services work closely with social care, the voluntary sector, patients and the public to provide the best possible health care for local people. This is shown in the map below.

Map showing major health facilities in NEW Devon



* GP practice data from NHS England South, (South West Team), validated in September 2016

2 The current challenges facing the local NHS

The challenge of providing consistent, high quality, affordable healthcare in NEW Devon has become increasingly difficult. This is because:

- The ways in which we provide care for people are becoming increasingly outdated – despite the efforts of local clinicians and staff – we have not done enough to modernise our services using the rapid advances in health and care.
- Our services are not set up in a way to enable them to increase quickly to meet the needs of the growing population of elderly and those with increasingly more complex needs.
- People in NEW Devon are living longer, which is a good thing but this means more people have more complex care needs that require support from health and social care services.
- Local health and social care organisations face a financial shortfall in 2015/16 of £122m. This cannot continue – even after adjusting for the size, age and social factors of the area – it is one of the largest overspends anywhere in the country. The funding allocations to the NHS up to 2020/21 are set and additional funding will not be made available.

The Case for Change published in February 2016 highlighted key aspects of the need for change in Devon overall:

- There are 280,000 local people living with one or more long-term conditions such as asthma, diabetes, hypertension, cancer and mental illness.
- More than 1 in 5 people in NEW Devon are over 65 – higher than the national average. It will be almost 1 in 4 by 2021.
- A local study found that more than 600 people in local hospital beds could go home with the right support.
- There is not the right support for people who are frail, elderly or have long-term conditions to stay well and independent, and in many cases they end up in hospital because of a lack of alternatives. We forecast that there will be 37,000 more emergency admissions to local hospitals over the next five years, an increase of more than 30%.
- People with mental health conditions do not have access to the level of support they need which impacts on their general health and wellbeing.
- If we do nothing over the next five years to change services, we will face a £400 million overspend.
- We also have difficulties with recruiting and keeping staff at all levels and, like people living in our communities, our staff are getting older with many expected to retire in the next 10 years. We need to make sure we use staff – our greatest assets – as efficiently as possible.

The case for change is particularly compelling in relation to how we use hospital beds:

- People have told us that when they are ill, they would prefer to be at home and stay at home wherever possible, with appropriate support.
- Up to half of patients in community beds and over a third of those in acute beds are medically fit to leave hospital but require some support to go home
- Every day a patient stays in hospital risks causing harm, as muscle strength can be reduced by up to 5% per day, threatening their ability to return to independent life, and reducing their confidence to remain independent
- Stays in hospital can expose patients to the threat of hospital-acquired infection and other complications
- The key reasons preventing patients from returning home have nothing to do with medical care but include needing some short term support with washing or preparing meals, medications or dressing changes, physiotherapy or needing additional equipment to be safe at home such as rails or walking aids
- The cost of a hospital stay is £200-300 per day – which is money wasted if people are having to stay in beds longer than clinically needed
- The money lost on unnecessary stays could be used to support care at home, and contribute to reducing Devon's overspend.

In Northern Devon changes have been made to put in place better care by moving the money and staff from delivering care in a bed to care at home, and the experience there demonstrates how this can be done safely. In Northern Devon, where more people are now being treated in their homes, the number of beds needed in community hospitals has fallen from 74 to 32.

The level of community beds in Eastern Devon in relation to the size of population is double that of anywhere else in Devon. Given the number of people occupying beds who could be cared for at home, it makes sense to learn from Northern Devon and elsewhere in the country to make similar changes in Eastern Devon to deliver more care at home and reduce the number of community beds.

Providing safe, high quality care means making it consistent, at home where possible, using staff and money available effectively for your future care.

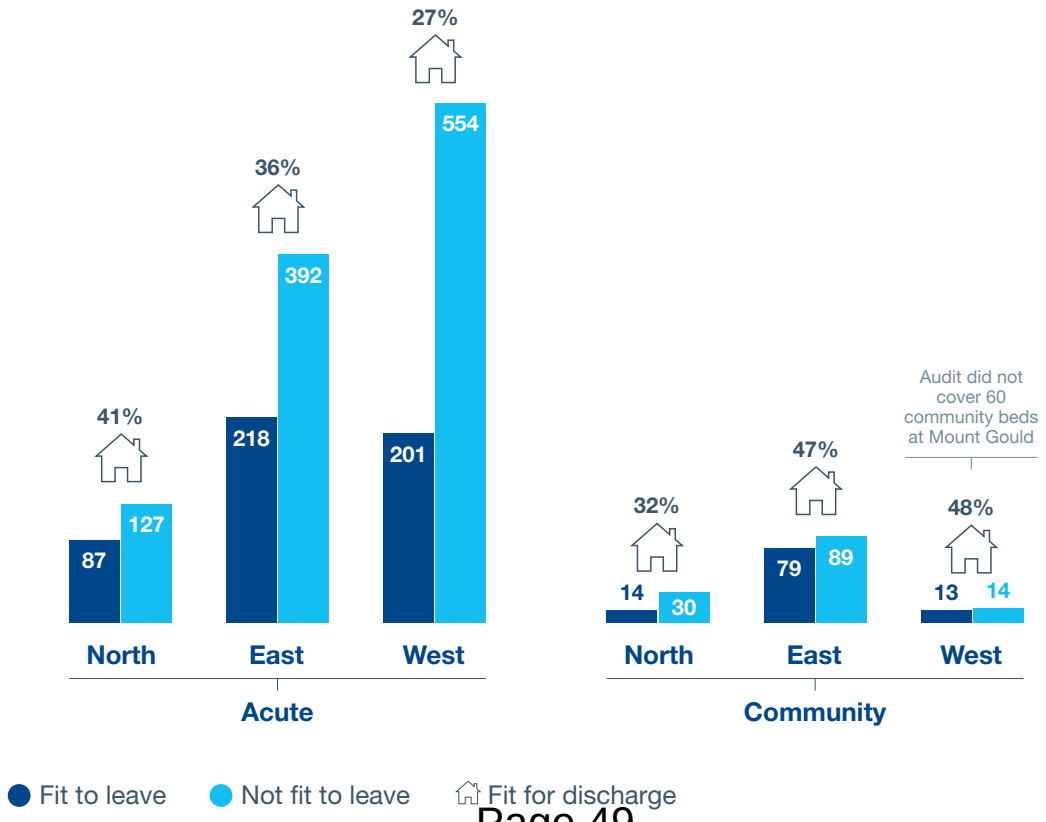
The National Picture

Our plans are not being developed in isolation and we have made sure that they align with what is happening in neighbouring areas and across the country.

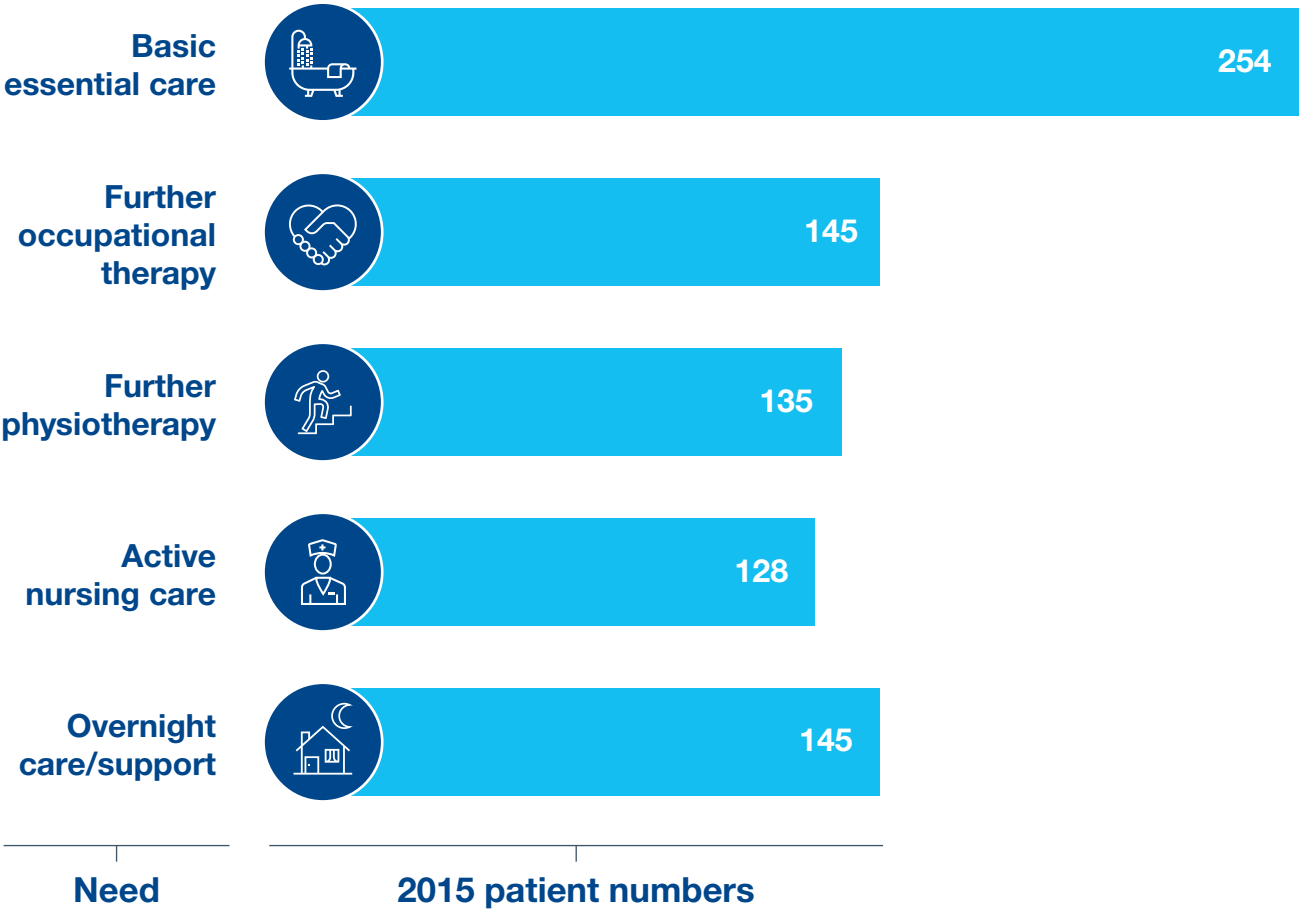
The NHS nationally has a five-year plan launched in 2014 called the **Five Year Forward View**. This sets out the direction for the NHS over the next five years and areas to focus attention for change to deliver the objectives set by Government for the NHS. The Five Year Forward View includes important themes such as prevention, care outside hospital and integration of care, as well as the necessity for change. This national plan describes the importance of giving people greater control of their own care, breaking down barriers between care delivered across different parts of the system, and integrating care. It emphasises the funding pressures and the need to address demand, efficiency and finances whilst engaging patients and communities. This aligns closely with our plans.

The **NEW Devon Success Regime** is a national initiative, locally-led, which has been established to help create the right conditions for high quality health and social care to develop in NEW Devon. Its aim is to secure improvement by introducing new care models where appropriate, developing leadership capacity and capability across the health and care system and ensuring collaborative working. These improvements are best achieved by involving doctors, nurses, other health and social care staff and members of the community.

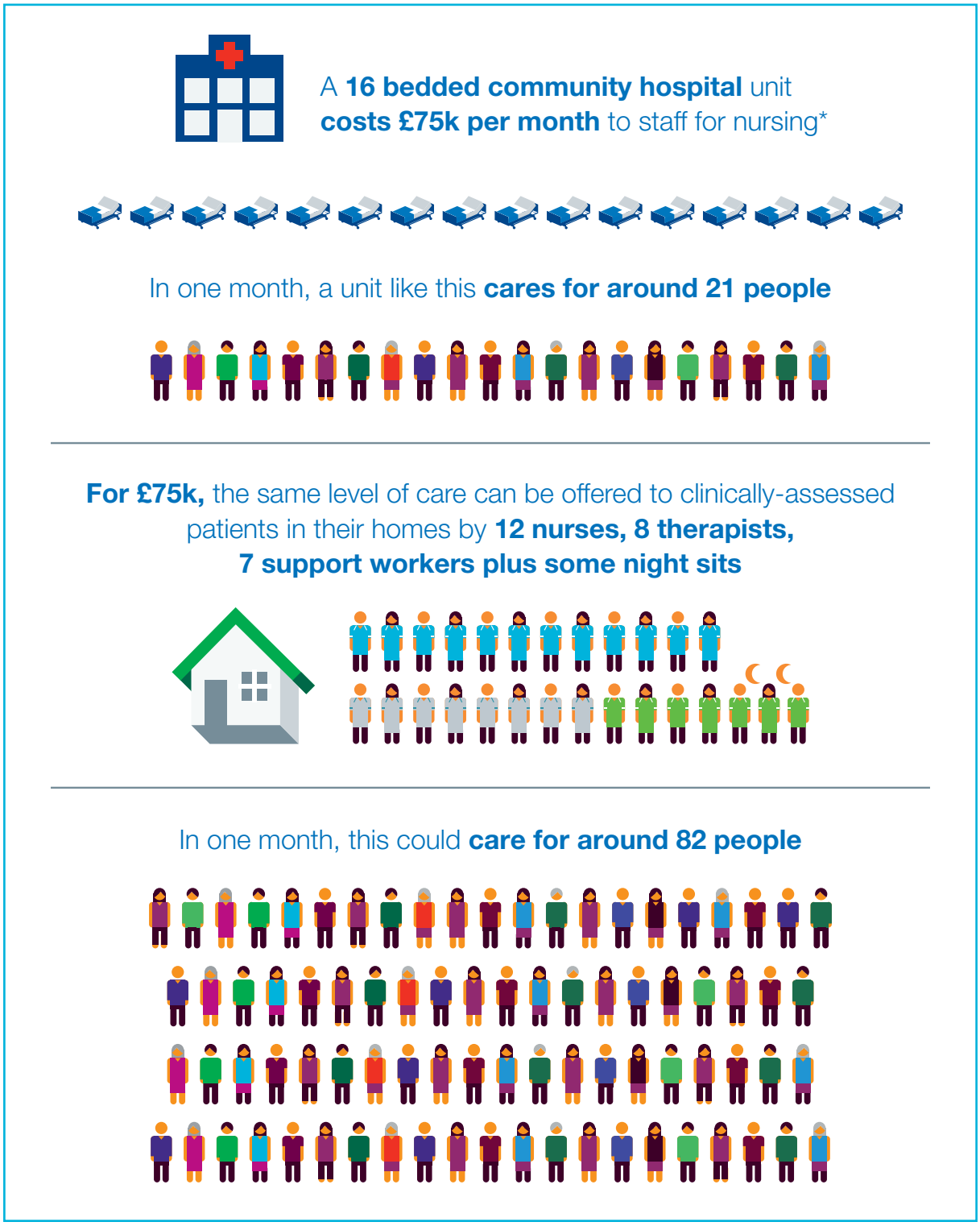
A graph showing the number of people who were in hospital beds who could have been cared for elsewhere, during an audit in NEW Devon in October 2015.



A lack of access to health care services at home or in the community was a key factor keeping patients who were fit for discharge in hospital settings. This is shown in the chart below.



The image below shows how many more people can be cared for in their own home compared with in a community hospital for the same cost.



*This is based on a daily £174/bed nursing cost in Eastern Devon (Referenced in PCBC finance appendix). This gives an annual nursing cost of £914K for a 16 bed site. Rounded down to £900k or £75K per month.

3 What we've improved so far

Over the past three years, we have extensively engaged with local stakeholders about the changes needed to deliver high quality, affordable healthcare. In 2014, we published, and consulted on, the Transforming Community Services (TCS) Strategic Framework.

This set out six strategic priorities for services, thus:

- Help people to stay well
- Integrate care
- Personalise support
- Coordinate pathways
- Think carer think family
- Home as the first choice

The priorities set out in the Transforming Community Services Strategic Framework were consulted on and the first phase of service changes have already been made towards achieving these strategic priorities. This includes confirming future arrangements for who will run integrated services in all three areas/localities.

Across NEW Devon at any one time thousands are receiving care in their own homes from teams of highly skilled social care, therapy and nursing professionals. Ten years ago many of these people would have been admitted to hospital. It is clear that this model is the right way to care for the growing number of patients with more complex health needs requiring our care in future.

Northern Devon locality

Northern Devon has made the most progress so far in developing the new model of care. Performance against national targets is better in Northern Devon than in other parts of Devon and in particular the traditional 'winter pressures' experienced across the country did not have the same impact in Northern Devon following the changes introduced ahead of winter 2015. These include:

- A single point of contact for GPs, carers, patients and wider health and social care which navigates the system to get the right support in place.
- A rapid response capability to quickly respond to patients whose health is deteriorating. This proactive support has been shown to enable people to remain in their own homes when it is safe to do so.

There has been closer working with the voluntary sector and mental health teams, and more integration between hospitals, community services and GPs. This has meant that:

- Patients are able to leave hospital more quickly.
- The enhanced community teams are able to offer patients support to avoid hospital admissions.
- With rapid response capability in place, the majority of people receive a visit from a multi-disciplinary team within 2 hours. This support also avoids hospital admissions. We have reduced the number of assessments needed so people do not have to tell their story multiple times.
- With more people treated in their homes, we have halved the number of community hospital beds across Northern Devon and removed beds entirely from Torrington, Ilfracombe and Bideford.
- The experience of patients receiving care and support in their own homes is regularly audited using the Friends and Family Test. Every month patients across Northern and Eastern Devon report consistently high levels of satisfaction (between 95 and 100%) with the service they receive.

Following the introduction of the model of care in Northern Devon, the Trust operated with 47 fewer beds last year compared to the 2014/5 winter (22 in acute and 25 in community). It was able to do this despite winter pressures, because people got the right care first time, at home and in the community, and so were able to avoid being admitted to hospital.

Because of the focus on proactive and out of hospital services over winter the acute and community services were resilient in the face of increased demand, which was in contrast to the experiences of prolonged escalation and 'red' alerts across the rest of Devon.

This model of care has been focused on providing services in the right place at the right time, and to the right standard.

Western Devon locality

Western Devon has made considerable progress on bringing care together with the local authority in Plymouth, so people have more coordinated care and support than was previously possible. New services based on a new model of urgent care have begun, which are reducing the number of people attending and being admitted to Derriford Hospital and the length of time they have to stay.

These include:

- The Robin Community Assessment Hub – a new service in the community at Mount Gould where 10 people a day can be assessed, treated and returned home quickly
- Acute Care at Home – a new service helping people to remain at home by offering a broader range of treatments, such as intravenous antibiotics
- Discharge to Assess – a new service aiming to return people to their own bed, with a package of intensive short term support available to allow a full assessment of long-term need to be undertaken away from the hospital
- National best practice to hospital based process – known as the SAFER bundle – being implemented in Derriford Hospital with support from the national Emergency Care Improvement Programme team.

Eastern Devon locality

The first phase of the TCS strategy was implemented in 2014/15 and we were clear in our commissioning intentions that we would continue pursuing an out of hospital model of care and further bed reductions. Whilst we have made really good progress in implementing the community model of care, not everyone in the area currently has consistent access to these services, and we need to ensure more people are helped to live independently in their own homes.

In Eastern Devon, some consolidation of community hospital beds has taken place with the closure of beds in Axminster, Budleigh, Crediton, Moretonhampstead and Ottery St Mary.

There have been developments in different parts of Eastern Devon including:

- Hospital at Home – an innovative service which provides health and social care support in Exmouth, Budleigh Salterton and Woodbury. The service was launched in 2011 and sees nurses, physiotherapists, occupational therapists and social care workers visit people in their own homes. It helps patients stay at home during their treatment and remain independent, while receiving similar care to that usually given on a conventional hospital ward.
- Single Point of Contact for GPs – one phone number to ensure a rapid response for people needing health and social care services is in place for people in Axminster, Seaton, Honiton, Ottery and Sidmouth.
- Integrated Care in Exeter (ICE) – this delivers high quality, cost effective, sustainable health and social care services. It brings together Devon County Council, Exeter City Council, Devon Partnership NHS Trust, Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare Trust and Age UK to promote independence for adults with complex needs.
- From 1st October 2016 acute and community services within Eastern Devon will be provided by Royal Devon and Exeter NHS Foundation Trust. This will mean closer working between acute and community services and improved partnership working with social care to implement a new model of care.

The key theme running through all the approaches in Devon detailed above is how each locality is responding to the changing needs and expectations of the public. Patients and the public have told us they want us to put the services in place that prevent unnecessary admissions to hospital. And that hospital admissions – when they are required – should be for the shortest time possible, based on clinical need, and patients should be discharged home as soon as it is safe for them to be there. The majority of patients go straight home after hospital, but where support is required it is really important that the skills and expertise are in place to help people regain their health and independence in their own homes.

Across NEW Devon, patients are already being cared for in their own homes by health and social care teams, working well together to meet their needs, but the model is inconsistent. We have seen compelling evidence from Northern Devon of how patients can benefit from a consistent and resilient model of care, as proposed by this consultation. Northern Devon has gone the furthest in showing how enhancing the community model means fewer acute and community beds are needed. We want to see a consistent, high quality, common standard of care that is available to everyone in NEW Devon.

4 What we want to do next: Your Future Care

Over the last 12 months, local clinicians have been further developing the model of care for health services, focusing on patients who are likely to benefit the most. These are frail and elderly people, people with dementia and people with long-term conditions affecting both their physical and mental health. In the short term, this is about doing the same better. Over time, the model will evolve with greater focus on prevention, population health and wellbeing.

The aim is to join up care more effectively so people are not being sent to hospital just because services are not available to look after them at home.

For frail and elderly people, a prolonged stay in hospital can cause harm, increase risk of exposure to infection and reduce their ability to live independently at home. People have told us they would prefer to be in their own homes. Whilst people do sometimes need treatment in hospital, it is essential that they are then able to go home as soon as they are well enough and it is safe for them to do so.

There is a real opportunity to get services right. Local clinicians want to deliver better care as early as possible and have been learning from successful schemes locally and nationally.

An integrated model of care to help people stay well and at home

Over 80 clinicians and social care professionals have worked together over the summer to shape an integrated model to transform the care of people who are frail and elderly, building on existing services to deliver truly joined up care. Three interventions have been agreed to deliver key aspects of the new care model.

These are:

1. **Comprehensive assessment.**
   Identify people who are frail or pre-frail, and therefore at risk of admission to hospital; put a care plan in place, owned by the individual, that outlines potential avenues for escalating care when it is required.

2. **A single point of access.**
   One phone number that will make getting additional support when it is needed urgently as easy as possible. It will be connected to a Comprehensive Rapid Response service.

3. **Comprehensive Rapid Response (Care at Home) Service.**
   This will help people to remain at home with support, rather than being admitted to hospital and where hospital admission is unavoidable, it will provide the additional support at home that makes it safe to leave hospital. This will include health and care workers delivering rehabilitation alongside traditional care.

These interventions are summarised in the box below and then described in more detail:

Comprehensive Assessment	Single point of access	Rapid Response
• Identifies people who are frail or becoming frail and more likely to be admitted to hospital. • Puts plans in place that help people to be supported and remain well at home. • Assessors act as 'community connectors' to support resilient communities.	• Makes organising care at home as easy as care in hospital and 24/7. • Referral can be made by any care service – with a clinical conversation based on patient need. • A home-based 'first responder' service available within 2 hours to help support people to stay at home.	• Multi-disciplinary team to respond to the needs of people at home and in residential and nursing homes. • An initial assessment of need undertaken and a package of care at home applied. • Rapid Response Team has access to additional capability and input – including through the acute sector.

Comprehensive Assessment

The aim of assessment is to identify people who are frail or becoming frail and ensure there is an agreed plan in place to support them if their health deteriorates.

Assessment and planning is completed by trained staff who may or may not be clinical, recognising that non-clinicians may obtain a more accurate picture of need. Assessors will coordinate available sources of formal and more informal information, such as health records and discussion with carers and families, and work with people to produce their plan. In addition they would help connect people with voluntary groups, and work with social prescribing to ensure people are supported to remain well and retain their independence.

Single Point of Access

This means a single telephone number which can be called by a health professional, a patient, or a carer when faced with the need to access advice and services quickly.

The single point of access is designed to make access to care at home as easy as care in a hospital, and available 24/7. Referrals can be made by any care service, including but not limited to domiciliary care teams, community nurses, GPs, paramedics, mental health teams, care homes and hospital services (Emergency Department, rapid discharge teams, elderly medicine etc.) The aim is to identify what a patient needs to keep them safe and at home as an alternative to hospital.

Referrals are received by a nurse, therapist or a doctor with the right knowledge and skills to help put in place the services the patient needs. They have access to the comprehensive assessment record so they are fully aware of the patient's circumstances and health.

It is important to emphasise two things that this is not. It is not an ambulance – if there is urgent need for care to be provided and for transport to hospital, then an ambulance will still be called. Equally it is much more than a general advice line for the general public.

This service determines the most appropriate first responder for the patient, and ensures this is timely and within 2 hours of referral. Once the referral is made, they will assume responsibility for liaison with the patient and/or family.

Rapid Response (Care at Home)

If the person has an immediate health need, the rapid response multidisciplinary team will visit the patient within two hours in their own home.

The team includes:

- Community nursing
- Therapists
- Health and Care assistants
- Access to medical input
- Staff who can prescribe and give drugs and medicines
- Mental health workers
- Administration support
- Domiciliary care workers

While most care will be delivered in patients' homes, the rapid response team will also support patients in residential and care homes.

The team undertakes an initial assessment of need and then institutes a package of care at home which can include support from a range of nursing, therapies, domiciliary support and night sitting. Where care needs exceed the capability of the team, they will escalate directly to the most appropriate level of care, including the acute sector.

The team will ensure the patient's lead medical carer (usually their GP) is kept informed of progress, but the responsibility for care, including escalation to hospital-based services as required, will remain with the team for up to 72 hours. Care may be decreased sooner than 72 hours if the patient no longer needs it.

The team will work alongside existing care providers to coordinate their input. Where a package of care is already in place, the team will support and build on this rather than make new care arrangements, so as to maintain continuity as far as possible

The same team supports patients when they are discharged from hospital, so this can happen as soon as it is clinically safe, accessed via the single point of contact. This will result in a managed transition between care settings. Home care workers, whether delivering health, personal or domiciliary care, will work with patients to achieve specific rehabilitation and re-ablement goals.

We want to give greater clarity and confidence to patients and professionals that care will be readily accessible, resilient and organised around the needs of the community served.

Where will care be provided in future?

The three interventions being put in place can from a patient point of view be delivered at home — either in person from visiting health and care staff, or by phone, or other electronic methods (where that is practical and useful).

- Assessments will usually be carried out at a local centre, or at home.
- The single point of access will be by telephone and so from home, but could also be from other places such as a GP practice.
- Rapid response will be delivered at home, or in a care or residential home if that is where the patient is.

These are the three foundation stones of our community model and create the infrastructure to move care out of hospital and into patient homes.

By providing responsive, timely and multi-disciplinary services in the community and patient home, we can avoid hospital admissions. In hospital, we can avoid delays to discharge by:

- Ensuring a plan for discharge is made at the point of admission to hospital, and that patients get the therapy they need to maintain mobility during their inpatient stay.
- Enhancing care coordination to facilitate transitions of care both into and out of hospital, including the ability to commit a care package within two hours to support discharge.

It is primarily through these interventions that clinicians believe we can have a much greater beneficial impact on people's lives.

The changes outlined here are the first step towards delivering more services that are joined up and provided in, or near to, the places people live. In modern day healthcare, hospital is no longer the first choice for care. Instead services should focus on supporting people to stay as well as possible for as long as possible – helping them to remain independent in their own communities. In the future we see:

- More support and care will be provided in peoples' homes either through home visits, regular checks over the telephone or other technology (including telemonitoring and telecare).
- Where it is not practical to deliver care at home, more care will be provided in the community (for example, face-to-face consultation or group therapy).
- Only where there are good clinical reasons will people travel to hospital for treatment – reducing unnecessary, sometimes physically painful and/or costly trips.

The Transforming Community Services programme put forward the idea of **health and wellbeing hubs** to supplement this model. A hub is a focal point for modern day integrated care. It could be based in an NHS or public service building such as a hospital or General Practice, or an alternative local building. A hub could also be a network of professionals and communities working together on place based improvements. The services offered could be virtual, may vary in size and function depending on local needs and range from bases for multidisciplinary teams to 'one-stop' centres for GP services, diagnostics and outpatient appointments.

The development of these is already underway. Importantly, hubs are designed with and by communities.

Locally, much of the early work has been building-focused, but as thinking develops the opportunities of place-based networked hubs will also be taken into account.

Hubs will be a focus for integrated care and community teams. At this stage we are not being prescriptive about what hubs should look like.


THE
BEDFORD
HOTEL

What will our proposals mean for people receiving care, their families and carers?

John and Mary are similar to our typical users of health and care services in NEW Devon. Although there is a rich mix of different types of communities across our area, we know that the vast majority of patients whose care will be transformed by the integrated model fit the profiles of John and Mary. We have therefore used these fictional people to explain how local services affect them now, and how our proposals for change would affect them in future.

Although they are fictional for the purposes of this document, the information we have used to create John and Mary is very firmly based on the wealth of evidence we have about our patients in NEW Devon.

John

Mary

John is 88 and cares for his wife. He has a urinary infection which because he is elderly starts to affect his balance. As a result he falls at home, an ambulance is called and he is taken to the Royal Devon and Exeter Hospital.

Now

- John stays in hospital a number of days. He develops a blood clot in his leg, which then needs treating.
- The length of stay in hospital means that he has become weaker and can no longer move around easily, for example using stairs.
- It also means that family need to come and help look after his wife while he is away.
- Once John gets better, doctors and nurses need to organise what help and equipment he and his wife will need when he goes back home.
- So he is moved from the acute hospital bed, which is needed by more seriously ill patients, to a community hospital bed, while this care at home is organised for him.

Future

- John's community nurse has assessed him as frail and noted his home circumstances on his health record. As part of the care plan developed with him, John has been connected up with a local carer support network, which is in regular contact with him and supports him as the sole carer for his wife.
- Following his fall, the ambulance paramedic who is called out to see him contacts the rapid response Care at Home service and John's GP.
- The Care at Home service sends a senior nurse to John's home, and recognises that he has a serious urinary infection. If necessary, a GP will visit him. Arrangements are made for him to be seen in hospital, and care is put in place for his wife including a night sitter in case John cannot return home.
- John needs hospital treatment for his infection. After 24 hours he no longer needs to be in hospital however so the ward liaises with the Care at Home service which arranges some short term care for John and his wife, to help with daily activities such as getting washed and dressed. They also organise additional equipment for their home, such as handrails, to reduce the risk of further falls.
- John is able to return home that day. The Care at Home team continues to care for him at home for the next three days with regular nursing visits, physiotherapy and occupational therapy.
- John makes a full recovery, and the care and support is reduced back to the same level as before.

Mary is 82 and lives alone. She has been increasingly forgetful and has been diagnosed with dementia, but is managing well with some help from family and social care support.

Now

- Following a chest infection, Mary is admitted to the Royal Devon and Exeter Hospital.
- During her stay, she becomes very confused because of the new environment she is in, and it is clear to doctors and her concerned family that her dementia has become worse as a result.
- The infection has made her more unsteady on her feet and she has two minor falls while on the ward.
- When she has recovered from the chest infection she is moved to a community hospital to see if she improves; if not she will need full time care potentially in a care home.

Future

- Mary has been identified by her GP as being at risk of emergency admission to hospital and there is a clear plan in place to avoid and manage events that could lead to this. She is regularly visited by care workers, as well as her family, who help her with bathing and getting dressed. Her care worker calls her GP when she sees that she is frequently coughing and seems short of breath.
- The GP visits and gives Mary some antibiotics to help her chest infection. He also contacts the Care at Home team via the Single Point of Access to ask for additional support. They all know it is important for Mary to remain at home, as she could get very confused if she was moved to a new environment.
- So the team coordinates physiotherapy twice a day, more regular nursing visits, and someone to stay with her overnight to keep her safe at home.
- The chest infection is causing Mary to be more confused than usual, but with the additional support this is manageable.
- Each member of the team has additional skills in caring for patients with dementia, as well as access to expert advice if they need it, and is able to give Mary the care she needs.
- After three days of antibiotics, Mary's chest is much better. Mary's care plan is reviewed with her, and the level of ongoing support she needs is altered.

Who will provide care?

Staff are our greatest asset and they are dedicated to delivering high-quality care. Whatever their role, they need to have the right skills, experience and tools.

Changes to how and where care is delivered will inevitably mean staff will need to work in different ways developing new skills and competencies, providing care potentially in different places.

Staff will work together in an integrated way and the focus will be on caring for people in their own homes safely. The reduction in community hospital beds will mean that the staff who currently work on the wards will transfer to join the community health and social care teams in their locality. There will be no need for any compulsory redundancies associated with these proposals, as we will be able to redeploy affected staff within different settings or neighbouring organisations. In particular there will be roles to deliver care in peoples' homes as part of the new services, as well as filling vacancies, and reducing the reliance on temporary staff.

From our experience of successfully managing this transition in communities where services have already changed, our providers will offer staff excellent training and support to undertake the new role.

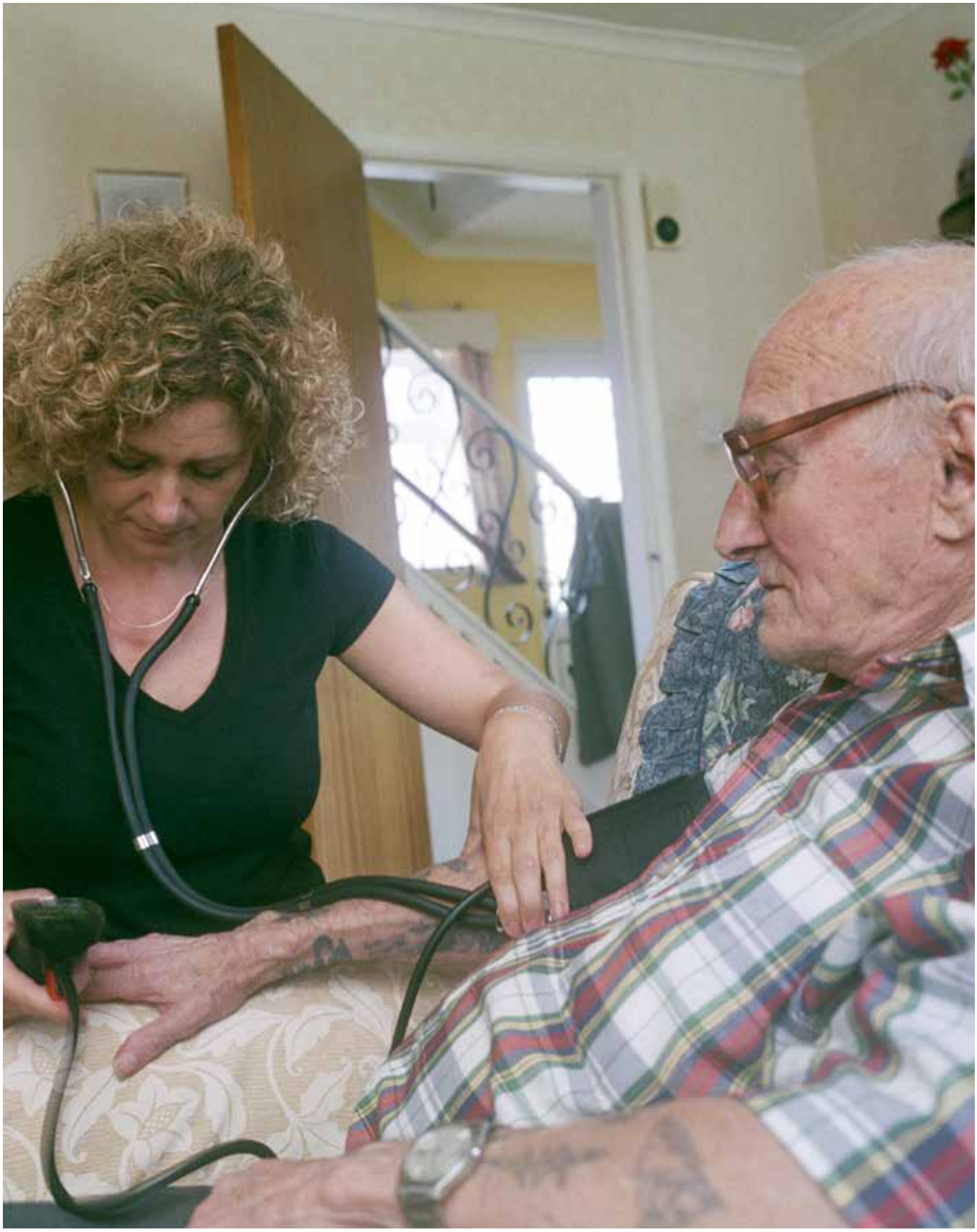
Experience in Northern Devon indicates implementing the new model of care has not created additional work for our already hard-pressed primary care teams. Further work will be undertaken to confirm this is the case across the NEW Devon area and as implementation plans are developed our primary care workforce will be an important element.

A detailed **workforce strategy** will be developed to support the further implementation of the new model of care. This will include a more detailed analysis of the staff, roles, skills, competencies and training required. This strategy will form part of the final decision-making business case. We recognise that the successful implementation of the new model of care will not shift pressure from one point in the system to another. We will work to ensure that existing pressures and new demands on existing primary and community based workforce through the new model of care are mitigated by actively redeploying workforce from bedded care to new model of care delivery.

An **estates strategy** is being developed to make sure best use is being made of the buildings that currently support delivery of primary, community, mental health, acute and social care. When completed it will set out in detail the future use of the buildings required to support the care delivery models. This will include how existing buildings will be used to support the model of care described, including hubs and other care services.

Some of the hospitals from which inpatient beds could be removed would continue to be local health and social care hubs, housing integrated teams that provide enhanced home and outpatient care, and other services such as therapies.

We will not be making any decisions on the future of buildings within the NEW Devon estate as part of the Your Future Care consultation. Members of the public will have the opportunity to comment on the estates strategy at a later date.



5 What service changes are needed?

Implementing the new model of care across NEW Devon will bring about improved care within home and community settings with less need for community hospital beds – this will improve health outcomes for patients.

Across Devon we have an unequal distribution of community hospital beds. Our clinical cabinet of doctors, nurses and other professionals has reviewed this data which shows that Eastern Devon has much higher numbers of beds per person compared to Western or Northern Devon, even after the older population is taken into account, and for the patients in those beds, almost half (47%) could go home if services were available in the community.

If the new model was implemented and working well with patients only hospitalised for as long as necessary then evidence and the experience in Northern Devon, suggests that the Eastern locality would need 72 beds at this stage, compared to the current number of 143.

The next sections of this consultation document explore how to determine the best locations for 72 community beds in Eastern Devon to ensure we release the resources to enhance the community health and care teams.

Proposals for Eastern Devon

There are seven community hospitals in Eastern Devon that have community beds. These community hospitals also provide a range of day services including minor injury units, x-ray, day case units, maternity services, therapies, outpatients co-located primary care, endoscopies, mental health services and services provided by the voluntary sector. Different services are provided at each community hospital, as shown in the table on the next page.

The map below shows community hospitals in Eastern Devon with beds and the numbers of beds in each.

* On an interim basis, Ottery St Mary is currently providing stroke unit care and three community inpatient beds.

Community hospitals provide a range of services:

Community Hospital	Midwife-led birth units	Minor Injuries Unit	Therapies	Out-patients	X-ray	Surgical day case	GP collocated primary care	Endos-copy
Axminster	—	—	✓	✓	✓	✓	—	✓
Seaton	—	—	✓	✓	—	—	—	—
Sidmouth	—	—	✓	✓	✓	✓	—	—
Honiton	✓	✓	✓	✓	✓	—	✓	—
Ottery St Mary	—	—	✓	✓	✓	—	—	—
Exmouth	—	✓	✓	✓	✓	✓	✓	—
Budleigh*	—	—	—	—	—	—	—	—
Exeter	—	—	✓	✓	—	—	—	—
Crediton	—	—	✓	✓	—	—	—	—
Tiverton	✓	✓	✓	✓	✓	✓	✓	✓
Okehampton	✓	—	✓	✓	✓	—	—	—
Moreton-hampstead	—	—	✓	✓	—	—	—	—

*Budleigh Salterton Hospital is temporarily closed. During the closure, the majority of outpatient clinics and services have switched to Exmouth Hospital. Other services have moved to other nearby venues.

Applying longlist criteria

To reduce the options to a manageable number, we agreed the following principles:

- **No new build due to cost and timescales:** Clinicians have recommended that only the existing community hospital sites should be considered for future location of community hospital beds. New sites are not suitable due to the timescale required to find and develop any site. Equally, clinicians and finance teams have recommended that there should be no new building on existing community hospital sites given the timescales and costs, and given the existence of current community hospitals whose space is currently not being fully utilised.
- **Ensures changes already consulted on are implemented:** There was a consultation on the location of community hospital beds in Eastern Devon in 2014/15. The decision from this consultation was that community hospital beds would be removed in Axminster, Ottery St Mary and Crediton. This decision has already been taken, and is therefore not affected by this current consultation.
- **Makes best use of Private Finance Initiative (PFI) / Local Improvement Finance Trust (LIFT) services:** PFI is a scheme for funding new hospital buildings, where the health service enters into long term arrangements to rent back the property from private companies who have borrowed money in advance to finance the initial capital costs of building the facilities. Under PFI and LIFT, the local health service has entered into long term arrangements to rent back property from private organisations who have borrowed the upfront costs to build the premises.

The high costs of exiting these contracts and the generally high quality of the buildings mean it is sensible to make best use of PFI and LIFT premises. There is one hospital in Eastern Devon that fits all of the criteria and is PFI-funded – Tiverton Hospital – built in 2004 with a contract that runs until 2034 and which would cost approximately £35m to exit. Clinicians and finance leads have therefore recommended that 32 beds at Tiverton should continue to be used in all options, as best use of this space within this period. **Therefore 32 of the 72 beds required will be at Tiverton in all options.**

- **Meets agreed minimum size of unit:** Safer staffing guidance suggests that the minimum number of beds per unit should be 16. This is the most effective and safe nurse to patient ratio and avoids situations where registered nurses on the wards work on their own, without any professional support or supervision (what we call lone-working). Clinicians and finance leads reviewed the evidence and agreed that a minimum unit size of 16, with additional beds in multiples of 8, was required to make sure there are enough staff and to get best value for money. **Therefore, the remaining 40 beds required will be provided in one unit of 16 and one unit of 24 (no unit except Tiverton can provide more than 24 beds without new building works). Some community hospitals only have space for a 16-bed unit without new build, and are therefore not being considered as a 24-bed unit.**

This results in 15 possible options for the location of community hospital beds in Eastern Devon. These are shown on the table below.

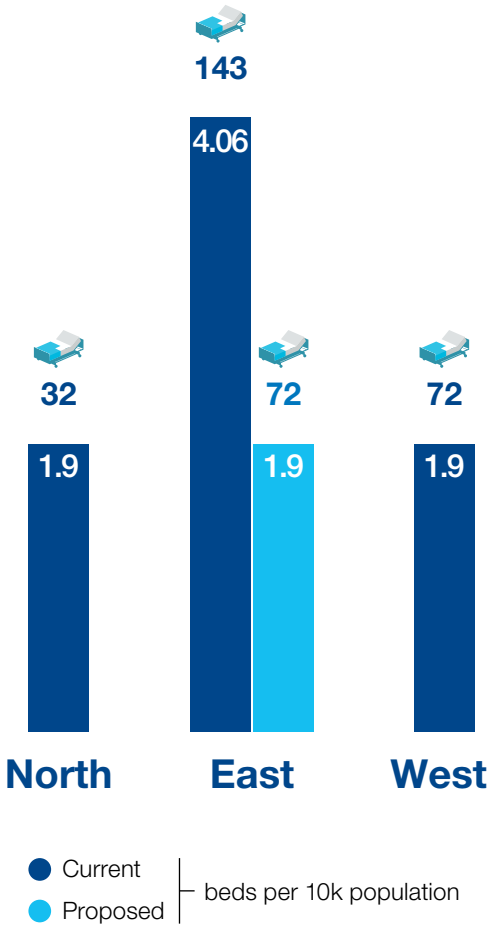
Options	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
32 bed unit	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton
24 bed unit	Seaton	Seaton	Seaton	Seaton	Seaton	Exmouth	Exmouth	Exmouth
16 bed unit	Sidmouth	Honiton	Exmouth	Exeter	Okehamp-ton	Sidmouth	Honiton	Seaton

continued...	Option 9	Option 10	Option 11	Option 12	Option 13	Option 14	Option 15
32 bed unit	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton
24 bed unit	Exmouth	Exmouth	Sidmouth	Sidmouth	Sidmouth	Sidmouth	Sidmouth
16 bed unit	Exeter	Okehamp-ton	Exmouth	Honiton	Seaton	Exeter	Okehamp-ton

Fixed point

Optional sites

Beds in East Devon will need to be reduced by 54% to be in line with the rest of NEW Devon



Shortlisting options

Clinicians and finance leads then analysed these 15 options further, and reduced them to a shortlist for consultation. The evaluation criteria used to do this were built on criteria used in previous public consultations in NEW Devon, including *Transforming Community Services*, *Pathways for the Future* and *Safe and Effective Care within a Budget*.

The evaluation criteria were:

Quality

Which options would provide the best clinical quality and patient experience?

Patient access

Which options keep to a minimum any increase in travel time?

Implementation

Which options can easily be put in place? Building work to reconfigure hospitals would be needed in some options.

Access for carers

Which options keep to a minimum the average travel time for carers, friends and relatives visiting people in community inpatient beds, and what parking space is available?

Finance

Impact on income and expenditure and capital costs of the service.

Ability to support whole system impact

Which options best support the wider system of health and care delivery? There are differences between the options as some hospitals already have other services being provided from them, and some have greater flexibility for other services to be provided onsite.

You can find all the detailed information and analysis we used to answer these questions in the Pre-Consultation Business Case on our website at **www.newdevonccg.nhs.uk/about-us/your-future-care/102019.**

Clinicians concluded that the following criteria are very important but do not differentiate between the 15 options (all options provide the same result and therefore the criteria cannot be used to choose between options):

- **Quality** in the new care model will improve to the same standard regardless of the option selected.
- **Patient Access** – Patients will be admitted to community hospitals when they require a community bed, and therefore patient access is no different between options.

Clinicians and finance leads carefully evaluated the remaining criteria and a shortlist of four options was reached. The following table shows the evaluation results for all 15 options.

- Our preferred viable option
- Other viable options
- Options we have evaluated as being less viable

✓✓ Highest evaluation
✓ High evaluation
– Neutral
✗ Low evaluation
✗✗ Lowest evaluation

Summary of Evaluation	1 Tiverton (32) Seaton (24) Sidmouth (16)	2 Tiverton (32) Seaton (24) Honiton (16)	3 Tiverton (32) Seaton (24) Exmouth (16)	4 Tiverton (32) Seaton (24) Exeter (16)	5 Tiverton (32) Seaton (24) Okehamp'n (16)	6 Tiverton (32) Exmouth (24) Sidmouth (16)	7 Tiverton (32) Exmouth (24) Honiton (16)
Quality	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Implementability	✓✓	✓✓	✓✓	✓✓	✓✓	✗✗	✗✗
Patient access	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Access for carers	✗✗	–	–	✓✓	✗✗	✗✗	✓
Finance	✓✓	✓✓	✓✓	✓✓	✓✓	✗✗	✗✗
Whole system impact	✗	–	✓	✗✗	✗	✓	✓✓
	🔴	🔴	🟢	🟢	🔴	🔴	🔴

	8 Tiverton (32) Exmouth (24) Seaton (16)	9 Tiverton (32) Exmouth (24) Exeter (16)	10 Tiverton (32) Exmouth (24) Okehamp'n (16)	11 Tiverton (32) Sidmouth (24) Exmouth (16)	12 Tiverton (32) Sidmouth (24) Honiton (16)	13 Tiverton (32) Sidmouth (24) Seaton (16)	14 Tiverton (32) Sidmouth (24) Exeter (16)	15 Tiverton (32) Sidmouth (24) Okehamp'n (16)
	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
	✗✗	✗✗	✗✗	✓✓	✓✓	✓✓	✓✓	✓✓
	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
	–	✓✓	–	✗✗	–	✗✗	✓✓	–
	✗✗	✗✗	✗✗	✓✓	✓✓	✓✓	✓✓	✓✓
	✓	–	✓	✓	–	✗	✗✗	✗
	●	●	●	●	●	●	●	●

The four shortlisted options are as follows all including Tiverton as the 32 bed hospital:

- **Option 3:** 32 beds at Tiverton, 24 beds at Seaton and 16 beds at Exmouth (from now on referred to as option A).
- **Option 4:** 32 beds at Tiverton, 24 beds at Seaton and 16 beds at Exeter (from now on referred to as option C).
- **Option 11:** 32 beds at Tiverton, 24 beds at Sidmouth and 16 beds at Exmouth (from now on referred to as option B).
- **Option 14:** 32 beds at Tiverton, 24 beds at Sidmouth and 16 beds at Exeter (from now on referred to as option D).

There is a genuine choice about which of these is the best option for NEW Devon.

However, by a small margin, Option A (24 beds at Seaton and 16 beds at Exmouth) is the preferred option as this combination results in the smallest impact in travel time and has greatest benefit to the whole acute-community pathways of care.

Option A

Beds at:	**Tiverton**	**32**
	Seaton	**24**
	Exmouth	**16**

Option B

Beds at:	**Tiverton**	**32**
	Sidmouth	**24**
	Exmouth	**16**

Option C

Beds at:	**Tiverton**	**32**
	Seaton	**24**
	Exeter	**16**

Option D

Beds at:	**Tiverton**	**32**
	Sidmouth	**24**
	Exeter	**16**

In reducing the long list to a short list of options for public consultation, the CCG has and continues to have an open mind on other options. As a result, we welcome all views and will carefully consider all responses and analyse these against the decision making criteria. That will include options which are not currently in the consultation document, but that those providing responses suggest should be considered.

Current community hospitals not included in the four viable options

Honiton Hospital

All three longlist options that included Honiton scored less highly than the four shortlisted options when measured against the evaluation criteria. Honiton Hospital is close to a number of other community hospitals, including Tiverton, Seaton and Sidmouth. Having all the community hospitals very close together would mean some people would have to travel further than in the other options.

Okehampton Hospital

While there may be an impact for the population living in Okehampton, we have focused on understanding the impact on travel for carers. The impact on carers is mitigated by reducing the number of people needing admission at all, and reducing their length of stay in hospital through better care, including in their own home. If an extended stay in a community hospital bed is needed, Holsworthy and Tavistock are available, as beds serve the Devon population not just immediate area. To fill 16 beds requires a catchment of 85,000 people. For Okehampton, this would mean people travelling from nearly as far as Barnstaple and the outskirts of Exeter – resulting in longer travel times for the rest of population. The travel time calculations are weighted to the population of the catchment area for individual hospitals, and hence the impact this has is negative.

Current community hospitals included in some options, but with fewer beds

Exmouth Hospital

Exmouth Hospital is not a 24-bed hospital in any of the shortlisted options – but does appear with 16 beds in two of the four options in the consultation. Exmouth Hospital currently has two wards with 18 and 10 beds respectively. One ward (18 beds) is currently open. These wards have separate entrances, their own nurse station and separate ward clerks.

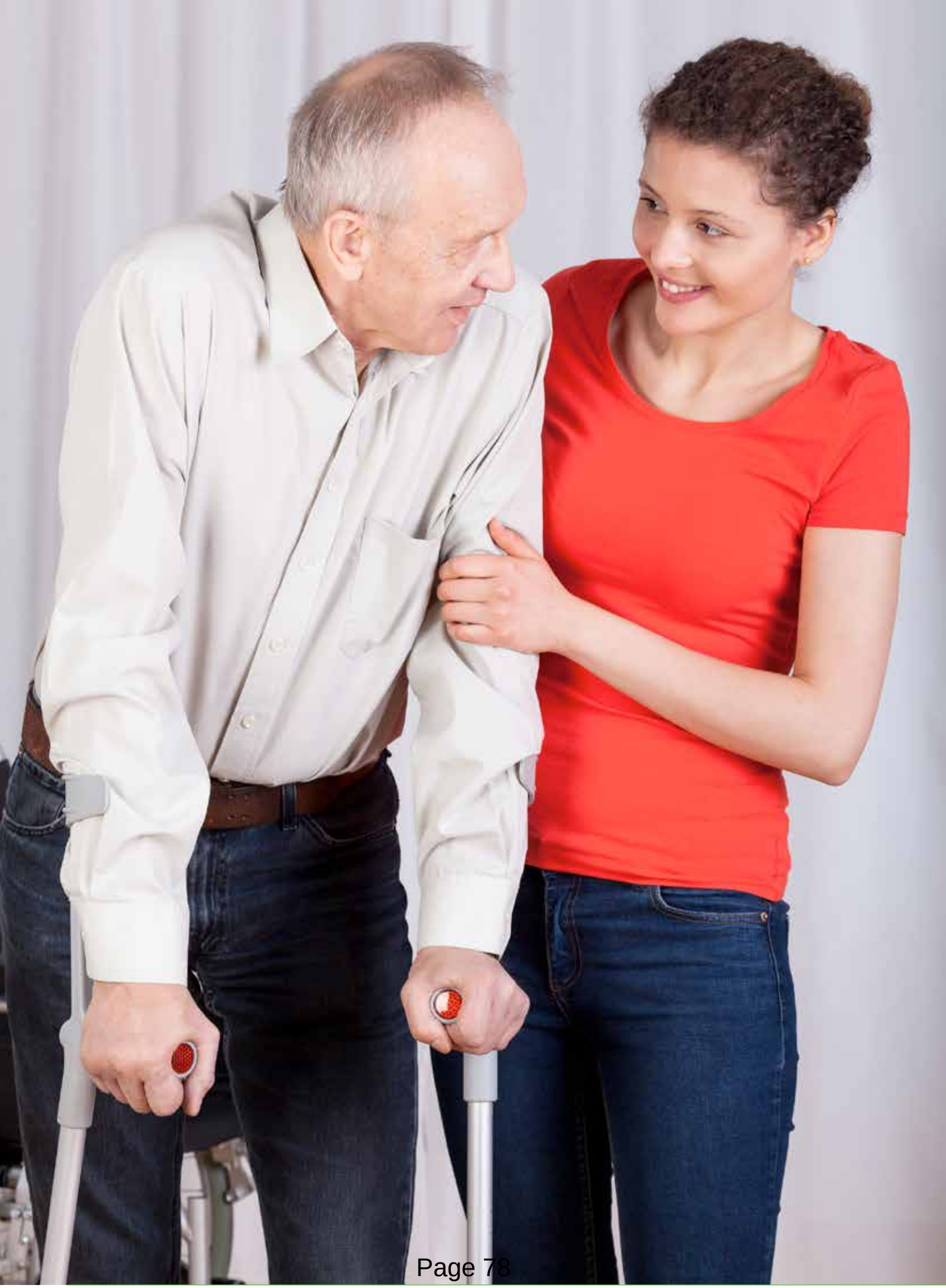
The building works to convert Exmouth's two current wards to a single 24-bed ward would cost up to £1.2m and take up to 18 months to complete – leading to temporary disruption to hospital services and delaying our ability to improve care for our patients. Options with Exmouth as a 24-bed hospital therefore scored poorly in the 'implementation' criteria, excluding this hospital from the shortlist as a 24 bed site. At Sidmouth Hospital and Seaton Hospital, there are existing wards which can accommodate 24 beds immediately.

Exeter (Whipton) Hospital

Whipton community hospital currently has 20 beds. They are unable to increase to 24 beds without investment for changes to the building, so 16 beds is the only suitable option for Whipton community hospital.

Other existing services in community hospitals are not affected by this consultation.

This consultation aims to gather people's views and we would welcome other options or proposals which show that they can improve local care, while better meeting the criteria described above. We will make sure that information is available so that anyone who is interested in making proposals is able to do so, and we will fully and fairly consider any further options.



We know from the changes we have made already under Transforming Community Services and other programmes that this can be done, so we can provide high quality, affordable care for local people.

Finance

NEW Devon health and social care organisations are facing a financial shortfall in 2015/16 of £122m rising to £384m in 2020/21 if nothing changes.

By applying the new model of care, we will not only be able to care for people better in their own homes but we will also plan to increase spending on community services by £1.4m – £1.9m.

We forecast the changes will save between £2.8m and £5.6m a year after the investment in additional community services has been made.

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

This work will support the next phase of our programme of change as we develop plans to ensure our acute and specialist services are clinically and financially sustainable. A timetable will follow and this programme of work will commence in October. The CCG will meet all statutory obligations when undertaking this element of the change programme.

Equalities

The CCG has two statutory duties, one under the NHS Act 2006 and one under the Equality Act 2010. Under the Equality Act 2010 a public authority (and a person exercising public function) is subject to the Public Sector Equality Duty. To inform our proposals an equalities and inequalities analysis was conducted to ensure that appropriate consideration has been given to the impact of the options under consideration on protected characteristics and protected groups within the context of the Public Sector Equality Duty.

It was determined that none of the evidence considered at this point identified differential or disproportionate impact on people or groups with protected characteristics in the scope of the Assessment. This means for all 15 options under consideration, none were identified as discriminating against vulnerable populations. If an agreed option for Eastern community bed reconfiguration is decided following consultation, the impact of the agreed option on protected characteristics or groups will be further tracked pre and post implementation, before wider change is decided on and rolled out across NEW Devon.

6 Safe and effective implementation

The safety of patients and staff is our top priority as our plans are implemented. As a Clinical Commissioning Group we would not support these plans if we did not believe they will provide a better, higher quality service for local people.

Following consultation, we will review all of the feedback to inform our final decision. Once the decision is made, implementation of the changes will start as soon as possible, delivering benefits in 2017/18.

We know that local people will want to be reassured that our proposals will have a positive impact on local communities and on the people living in them.

Local clinicians have therefore developed a series of 'tests' to make sure that changes to community services are safe and reliable when implemented. They build on themes identified in the Transforming Community Services Programme, including similar tests designed in Northern Devon. These tests will ensure that local clinicians have confidence in a safe implementation of the new model of care. They need to be passed before any changes are made.

A system for monitoring and measuring the impact of our proposals is also being put in place to help us make sure that the benefits are delivered as expected.

In total over 30 questions will need to be answered during the three phases – before, during and after implementation. To provide an illustration, questions before implementation include:

- Is there a robust operational managerial model and leadership to support the implementation?
- Is there an agreed roll out plan for implementation, which has due regard to the operational issues of managing change?
- Have the training needs of people undertaking new roles been identified including ensuring they are able to meet the needs of patients with dementia?

The main benefits from the proposed changes to the model of care will be improvements in:

- Clinical outcomes for patients.
- Patient and carer experience.
- The way staff work.
- Local financial pressures, due to money being saved

Further detailed information on implementation and benefits can be found in our Pre-Consultation Business Case, available on our website **www.newdevonccg.nhs.uk/about-us/your-future-care/102019.**

7 Your future care – next steps

We would like your views on the proposed changes set out in this document, which build on changes that have already started being put in place in parts of NEW Devon as a result of previous consultations. Once we have gathered these and properly and thoroughly considered them, we will report back, in public, on the outcome of this consultation prior to any implementation.

Devon County Council and Plymouth City Council's Overview and Scrutiny Committees will closely check our consultation process and will be consulted on our proposals.

A final business case will be produced which will be discussed by our Governing Body so that we can make a final decision.

We expect this decision to be taken in early 2017.

NEW Devon CCG will drive the commissioning process required to implement the changes through contracts and benefits-focused performance management.

8 Your views

We are keen to continue the discussion with patients, the public, and those who may be affected by the proposed changes to health services in the area.

There is a recognised process for doing this as, by law, the NHS has to consult patients and the public on any major change to local health services. Government guidance on this says:

1. Consultations should be clear and concise
2. Consultations should have a purpose
3. Consultation should be informative
4. Consultations are only part of a process of engagement
5. Consultations should last for a proportionate amount of time
6. Consultations should be targeted
7. Consultations should take account of the groups being consulted
8. Consultations should be agreed before publication
9. Consultation should facilitate scrutiny
10. Responses to consultations should be published in a timely fashion

Through a large-scale consultation running for 13 weeks from 7 October 2016 to 6 January 2017, we are asking people for their opinions on our proposals, making sure we involve patients and the public widely.

There will be events, meetings, focus groups and presentations, including with those who are sometimes referred to as 'hard to reach' groups. The aim is to discuss, to listen, and to receive views from as many people as possible.

The response form offers you the opportunity to express your views on some specific questions we would like answers to, as well as anything else you want to say.

9 Glossary

A&E	Accident & emergency is a service available 24 hours a day, seven days a week where people receive treatment for medical and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.
Acute care	Acute care refers to short-term treatment, usually in a hospital, for patients with any kind of serious or significant illness or injury that needs the specialist intervention of senior consultants, specialist nurses or diagnostics.
Acute trust	NHS acute trusts manage hospitals. Some are regional or national centres for specialist care, others are attached to universities and help to train health professionals. Some acute trusts also provide community services.
CCG	Clinical commissioning group. These are the health commissioning organisations which are led by GPs and represent a group of GP practices in a certain area. They are responsible for commissioning health and care services.
Care at Home	Medical care, as opposed to domiciliary (personal) care, that is provided at home.
Care outside hospital	Care that takes place outside hospital, in a community setting. This could be a patient's home or community health centre.
Case for change	In February 2016 the Success Regime published The Case for Change for NEW Devon. This set out the key challenges facing the NHS in NEW Devon – including health inequalities between different parts of the county, a large and growing financial deficit, and an over-reliance on hospital rather than community-based care. This can be found on the CCG website here **http://www.newdevonccg.nhs.uk/about-us/your-future-care/success-regime/case-for-change/101857**
Clinical Cabinet	The Clinical Cabinet membership includes GPs, and other clinicians from CCG member practices, hospital trusts and representatives from Healthwatch. The Clinical Cabinet provides clinical input and leadership to the development of service change and ensures that there are clinical advocates for proposals in each relevant service area.
Co-located	Where services or facilities are located together in the same place.

Community Hospital	Community hospitals provide a range of different services, but do not have the levels or type of staff or equipment to care for people who need immediate access to medical care or other services such as critical care. The services can include medical and nurse led clinics, some diagnostic tests, minor injuries units, midwife led birth units,or day case surgery. Some services are for the local community while others, such as day case surgery, may serve a much larger area.
Comprehensive Assessment	An assessment carried out by a trained member of staff, using available information and discussion with the individual, so that a plan can be agreed that outlines the type of support likely to be needed if that person becomes ill. The assessment will also help connect the person with the kind of support in their local area, that can help them keep well and independent. It will be undertaken with people who have been identified as frail, or likely to become frail.
CQC – Care Quality Commission	This is an organisation funded by the Government to check all hospitals in England to make sure they are meeting government standards, and to share their findings with the public.
Deficit	When spending is greater than income.
Endoscopies	A procedure that helps clinicians looking inside the human body.
Equalities	Things or outcomes that are the same.
Foundation trust (FT)	NHS Foundation Trusts are not-for-profit corporations. They are part of the NHS yet they have greater freedom to decide their own plans and the way services are run. Foundation trusts have members and a council of governors.
Frail/Frailty	Frailty is a health condition related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication.
Governing Body	The Governing Body is made up of GPs, clinicians, managers and lay members to ensure the CCG commissions the highest quality services within budget.

Glossary

Healthwatch	Organisations whose role is to make sure patients are involved in developing and changing NHS services and to provide support to local people. There is a national HealthWatch which oversees the local HealthWatch and provides advice as an independent part of the CQC (see above).
Health and wellbeing board (HWB)	Local authority bodies whose aim is to encourage joint working between the NHS and local councils across health and social care.
Hub	A setting for care outside hospital adapted from existing community sites to provide other services locally, serving as a support 'hub' to local healthcare teams, and not necessarily based on a particular building or site. The services offered could be virtual, may vary in size and function depending on local needs and range from bases for multidisciplinary teams to 'one-stop' centres for GP services, diagnostics and outpatient appointments.
Inequalities	Differences, used often in relation to access to services.
Inpatient	A patient who is admitted to a hospital, usually for 24 hours, for treatment or an operation.
Local Improvement Fincance Trust (LIFT)	NHS LIFT was a vehicle for improving and developing frontline primary and community care facilities. It allowed the NHS (Primary Care Trusts) to invest in new premises in new locations, not merely reproduce existing types of service.
Maternity	Relating to pregnancy, childbirth and immediately following childbirth.
NEW Devon	Northern, Eastern and Western Devon Clincal Commissioning Group.
NHS	National Health Service.
Overview and Scrutiny Committee (OSC), Health OSC (HOSC) and Joint Health OSC (JHOSC)	The committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and if necessary challenging programmes such as this. Parts of consultation, such as the length of the consultation period, have to be agreed by them.
Outpatient	A patient who attends an appointment to receive treatment without needing to be actually admitted to hospital, unlike an inpatient. Outpatient care can be provided by hospitals, GPs and community providers and is often used to follow up after treatment or to assess for further treatment.
Outpatients and diagnostics	For people who need specialist advice or investigation in hospital. This includes support for insulin-dependent diabetics or neurological conditions such as multiple sclerosis. It also includes minor surgery, ECGs, x-rays, ultrasounds, CT and MRI scans.

Patient and public engagement committee (PPEC)	A group whose role is to make sure the interests of patients and the public are represented in the NHS. Members usually include representatives of local hospital patient groups, local clinical commissioning groups, and NHS staff.
Primary care	Services which are the main or first point of contact for the patient, provided by GPs, community providers and so on.
Private Finance Initiative (PFI)	A scheme for funding new hospital buildings, where the health service enters into long term arrangements to rent back the property from private companies who have borrowed money in advance to finance the initial capital costs of building the facilities.
Single Point of Access or Contact	A single telephone number or point of communication which helps to organise services for patients.
Success Regime	With long-term difficulties in recruiting permanently to key clinical posts, a history of financial challenges, and the need to improve the quality of services across the area, the NEW Devon area has been selected nationally, along with Essex and West, North and East Cumbria, to take part in the regime. Organisations working in partnership under the NEW Devon Success Regime banner include the five local NHS organisations and the two top-tier local authorities.
Telemonitoring/ telcare	Monitoring health using technology from a distance.
Transforming Community Services	Transforming Community Services is NEW Devon CCG's plan to provide preventative and personalised support, alongside urgent and specialist care, in local communities.
Your Future Care	The term used to refer to the consultation for NEW Devon's Success Regime.

Notes

Contact us

Telephone: 01392 267 642 **E-Mail:** d-ccg.YourFutureCare@nhs.net
Write: Freepost YOUR FUTURE CARE (no stamp required)

YOUR FUTURE CARE

Your Response

As part of the Your Future Care consultation, we want to make sure that everyone in Northern Eastern and Western Devon has the chance to give their views and comments. We are asking as many people as possible to give us their views by reading the consultation document and completing this response form. You may add extra sheets if you need to. Alternatively, you can complete the same form online at www.newdevonccg.nhs.uk/about-us/your-future-care/102019

We are keen to hear your views, which will help us to make a final decision. Please bear in mind this is a consultation not a 'vote'. We will take all responses into account along with a wide range of other information.

Please read the consultation document all the way through, then give us your answers to the questions in this form. Our full consultation document is available on our website or pick up a copy from our community hospitals, GP practices, libraries and other public buildings.

As part of this consultation, we will be hosting a number of consultation events across NEW Devon, where you can learn more, speak to the programme's clinical leaders and let us know what you think. To find out more about events near you please visit our website, local press or contact us using the details at the end of this form.

Please send your completed response form by **Friday 6 January 2017** to **Freepost YOUR FUTURE CARE**. This must be written exactly as it is shown, including capital letters where indicated, and you will not need a stamp.

This document is also available in other languages, in large print and in audio format. Please do not hesitate to call us on **01392 267 680** or email **d-ccg.YourFutureCare@nhs.net** if you would like to receive it in one of these formats.

We look forward to hearing from you and thank you for your help

Your future care

To submit a response to this consultation, please record your views on this form and return to us via the details below. Whilst optional, It would help us to ensure we run a representative and full consultation if you include your town of residence and the first part of your postcode below.

1. Of the four options, which is your preferred option

   ☐ Option A Beds at Tiverton (32), Seaton (24) and Exmouth (16)

   ☐ Option B Beds at Tiverton (32), Sidmouth (24) and Exmouth (16)

   ☐ Option C Beds at Tiverton (32), Seaton (24) and Exeter (16)

   ☐ Option D Beds at Tiverton (32), Sidmouth (24) and Exeter (16)

   ☐ Other Option (please detail and specify in the space provided under section 2 below)

   The CCG's preferred option is Option A.

2. Please state the reasons for your choice below.

3. How well do you think we have explored the options in this consultation?

   ☐ Completely ☐ Very well ☐ Quite well ☐ Not well at all

   Please give reasons for your assessment.

4. If you selected 'Other Option' in Question 1 above, please indicate how your option meets the six strategic priorities (page 18 of the Consultation Document) and how it meets the decision-making criteria (page 39 of the Consultation Document).

5. What is your least preferred option and why?

6. Do you understand how this model intends to improve the care we offer people across Devon? If not, what questions do you still have?

7. When resources are limited, the NHS should prioritise the use of staff and funding to:

	Strongly Agree	Agree	Disagree	Strongly Disagree
Help keep people well for longer				
Treat people with the most complicated health conditions				
Care for people in their own homes or close to where they live				
Keep open all community hospitals				

8. Is there anything else you would like to tell us?

Are you a:

☐ Member of the public ☐ NHS employed staff

☐ NHS contractor (eg. a professional such as a GP, pharmacist, optometrist or dentist – specify below)

Town name / first part of your postcode (eg. EX1)
(required to ensure geographically-representative consultation)

To help put this information in context and ensure we are successfully reaching all parts of Devon, we would like to ask a little bit about your personal situation. Any personal information that you supply in this form will be kept confidential unless disclosure is required by law.

Age

☐ Under 16 ☐ 16-24 ☐ 25-34 ☐ 35-44 ☐ 45-64 ☐ 65-74 ☐ 75-84 ☐ 85+

Gender

☐ Male ☐ Female ☐ Prefer not to say

Gender identity (if appropriate)

If you identify as transsexual, transgender (in that you have effected a permanent change of gender identity) or as intersex, which group do you identify with?

☐ Transsexual ☐ Transgender ☐ Intersex

Work pattern

☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ In education ☐ Other

Sexual orientation

☐ Bisexual ☐ Gay Man/Homosexual ☐ Lesbian ☐ Hetrosexual/Straight
☐ Prefer not to say

Ethnic origin

Asian or Asian British

☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other

Black or Black British

☐ African ☐ Caribbean ☐ Other

Chinese or other ethnic group

☐ Chinese ☐ Other

Mixed

☐ Black/white Caribbean ☐ Black/white African ☐ Asian/White ☐ Other

White

☐ British ☐ English ☐ Irish ☐ Scottish ☐ Welsh ☐ Other ☐ Prefer not to say

How did you hear about this consultation?

☐ Information received in the post at my home
☐ Through a local event or meeting (please describe what this was)
☐ Through an article in my local newspaper
☐ On social media
☐ From my GP practice (please state which one)
☐ At my local library (please state which one)
☐ From a family member, friend or neighbour
☐ Other (please describe)

Contact us

Telephone: 01392 267 642 **E-Mail:** d-ccg.YourFutureCare@nhs.net

Write: Freepost YOUR FUTURE CARE (no stamp required)

This must be written exactly as it is shown above, including capital letters where indicated, and you will not need a stamp.

Your Future Care: *public consultation and engagement*

Operational Plan

***The following document summarises the consultation and engagement approach to Your Future Care (YFC). It is intended to be read in conjunction with Your Future Care consultation document, available* on the CCG's website.**

Overall approach

We will target people likely to be affected by the proposals to ensure that they have sufficient information on which to feedback.

We will do this using a mix of mediums and forums, channels and media responding to feedback, ensuring that people have as much information as possible on which to consider our proposals.

Resources are limited and we must make the very best use of free mediums to bolster 'paid for' channels.

Responsibilities

The consultation and engagement programme is the responsibility of the CCG. However, it is working closely with NHS and upper tier local authority colleagues to implement the plan.

The CCG's communications team is responsible for the planning and implementation of the consultation plan and approach.

Broadly:

1) All communications outside YFC to be treated as business as usual
2) Liaison with MPs/elected representatives over the YFC programme are coordinated by the CCG.
3) Media and social media responses on YFC managed by a media protocol.
4) NHSE requests for information are coordinated by the CCG.

Reaching people and hearing views

Consultation and engagement events

Overall approach

The CCG is *engaging* with people across the NEW Devon area on the model of care – and *consulting* in Eastern Devon locality on a reduction in beds as a result of the new model being implemented.

In practice this means we are planning a higher number of consultation *and* engagement and events in Eastern Devon locality with fewer engagement only events outside of this area

Three types of event are planned

1) Public meeting format in cabaret style and,
2) Roadshow/s
3) "Pop Ins" – inquisitive meetings with members of the public in public settings

Number of events

We will hold at least four events in each potentially affected community (7 communities in total). These are taking place in Exeter, Okehampton, Honiton, Seaton, Sidmouth, Exmouth and Tiverton.

In all other communities identified outside Eastern locality, we will hold one roadshow as a minimum.

There is potential for further public events in December in line with demand.

Timing

The events will take place from 24 October. This allows for just over 3 weeks from confirmation of CCG GB approval of consultation plans (28th September) and 2 weeks from the official start of consultation (7th October), allowing sufficient notice of dates and locations of events.

Purpose and rationale

Public events will be a discussion-based format which will allow for open conversation. To ensure we hear the views of as many people as possible – and manage the huge demand expected, these events will be ticketed and a small allocation of seats set aside for use on the day by people who will inevitably turn

up without a ticket. We recognise that the format reduces the number of people able to attend any one session and therefore we are setting up multiple events to mitigate this.

We will ensure that the message that it is necessary to book a ticket to guarantee a seat at each event but that everyone who would like to attend can attend. Additional events will then be set up according to demand. This message will be included in communication material about each event.

We will also:

- Have further events confirmed in the week following.
- Use presenters' time effectively – arrange multiple events in nearby areas on the same day, minimise travel times.

The purpose of the roadshows is to make people more familiar with the success regime proposals in a less formal environment. They will operate as a drop in session, allowing for informal conversation between the public and key well informed individuals.

FEEDBACK FROM EVENTS WILL FEED INTO EXTERNAL COMMUNICATION CHANNELS

Location selection

Location selection was based on local knowledge together with approaches to Exeter City Council, Teignbridge District Council, West Devon Borough Council, Mid Devon District Council, and East Devon District Council, Plymouth City Council and West Devon Borough Council to identify suitable venues.

Minimum requirements;

- Capacity for over 100 (cabaret style) in all venues. Larger venues can accommodate up to 220.
- Have, or ability to accommodate, sound and projector equipment
- At least 50 parking spaces plus additional if required
- Disabled access
- Chairs and tables
- Access to refreshment facilities

Proposed Locations

East Devon;

- Exeter
    - City Centre
    - Near Alphington
    - Near Pinhoe

- Moretonhampstead
- Okehampton
- Crediton
- Tiverton
- Cullompton
- Dunkeswell
- Chagford
- Woodbury
- Princetown (Dartmoor)
- Honiton
- Axminster
- Seaton
- Sidmouth
- Budleigh Salterton
- Ottery St Mary
- Exmouth

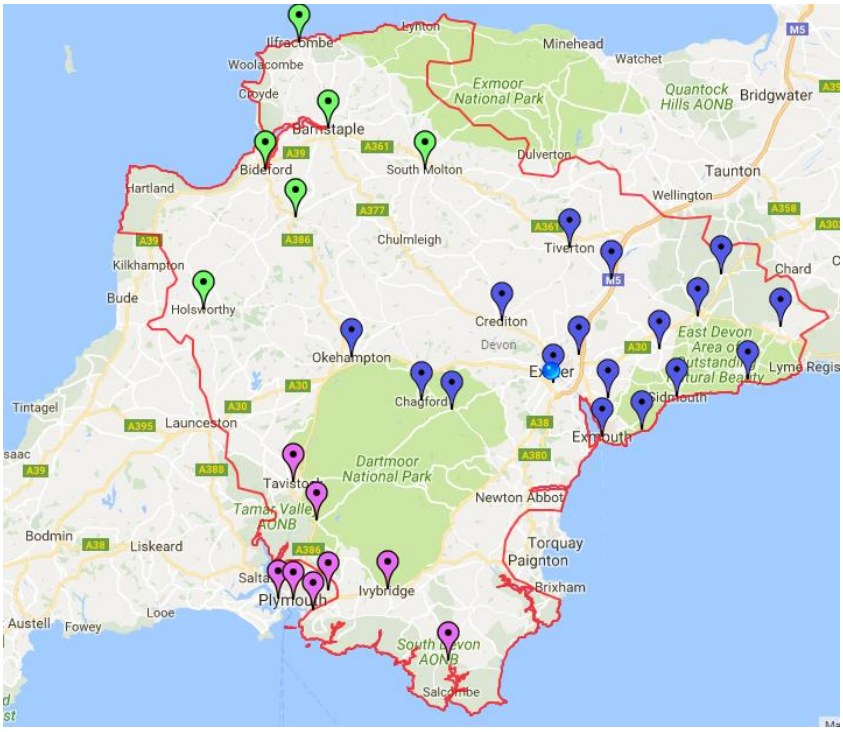
North Devon;

- Ilfracombe
- Barnstaple
- Bideford
- Torrington
- Holsworthy
- South Molton

West Devon;

- Plymouth
    - South - City Centre/Mount Gould
    - West - near Devonport/Keyham
    - North – near Derriford.
    - East – near Plymstock.
- Kingsbridge
- Ivybridge
- Tavistock
- Yelverton

The locations can be seen on the map below;



Dates – Public Meetings

The first phase of public meetings have been arranged for the Eastern locality.

These will be advertised widely, including in local media, through stakeholder newsletters and key stakeholder contacts. We will also be working with CCG Community Representatives to ensure local communities are aware of the opportunities to be involved. Details will also be published on the CCG website and promoted through social media. Where there is demand, further events will be added. **See flyer for events in Appendix 1.**

Dates – Roadshows

A full programme of roadshows (30+) is scheduled to take place across all three of the CCG's localities during November and December. Details for these will be published shortly.

Attendees (proposed)

Roadshows (see approach below)

- Clinician/s
- Manager/s
- CCG and provider communication team members
- HR representation
- Lay member/community representative

Public event (see approach below)

- Independent chair
- Angela Pedder or Ruth Carnall or Laura Nicholas or Rebecca Harriott
- Clinician/s
- Manager
- Plus in attendance, CCG and provider communication team representation HR representation, eastern locality administrative support, lay member/community representative

Approach

A ‘pool’ of potential speakers at events is being collated and approaches made by phone and email.

‘Pop Ins’

‘Pop Ins’ are a means of face to face engagement with local communities that will help us capture feedback from people who may not be able to access the consultation document through other routes. ‘Pop Ins’ consist of a member of staff visiting various locations and speaking to members of the public about the consultation and encouraging them to complete the response form.

The locations being targeted are primarily in the eastern locality of NEW Devon CCG and the populations specifically aimed at are the frail elderly. This is aligned to the over-arching communications and engagement strategy.

Our programme of ‘Pop Ins’ began week commencing **Monday 24 October** and continues throughout the period of public consultation.

The locations range quite widely and are intended to cover those places most likely frequented by our target audiences. They will include locations such as:

- Supermarkets (Tescos, Morrisons, Marks & Spencer, Lidl etc.)
- Garden centres
- Memory cafés
- Senior citizen’s clubs/lunch clubs
- Leisure centres

The above programme of ‘Pop Ins’ will be planned and carried out by the CCG’s Communications Team.

Key stakeholders

Key stakeholders have been identified and appropriate channels have been identified and are being used.

Overview and Scrutiny Committee (OSC), district council and town council approach

We are attending Devon County Council and Plymouth City Council health OSC and district OSC council events, where required to do so.

We are also attending the health and wellbeing board meetings.

We will prioritise attendance at town and district council meetings in addition to the public meetings.

Consultation responses

Consultation responses will be received by the consultation response unit (CRU), within the CCG. Questionnaires can be completed online, posted or emailed. People may also ask the CRU to fill in the details on their behalf.

CONSULTATION RESPONSE UNIT

1. CONTACT NUMBER IS 01392 267 642
2. FREEPOST Your Future Care (no stamp required)
3. d-ccg.yourfuturecare@nhs.net

Answering questions

Consultation Reponses officers will deal with all enquiries, recoding them on a spreadsheet and responding. Most enquiries should be able to be answered using the pre-prepared Q&A but others will follow a PMO tracking process. Weekly reports will be produced showing the numbers of enquiries and progress towards answering. These will then feedback into the Q&A which will be updated every Friday during the consultation period.

Handling and analysis of responses

Responses will be collated by the consultation response officers using online questionnaire software. This software also provide partial analysis. More detailed analysis of feedback, particularly in relation to the rich information within text fields, will also take place.

Consultation documents and distribution

Documents

There are two types of consultation document:

1) 60-page consultation document and,
2) 12-page summary consultation document

There are 187,000 homes in the eastern Devon area.

We have printed approximately 15,000 of the full document and 100,000 of the summary document. These will be accompanied by a questionnaire response form and FREEPOST envelope for return.

Distribution

We recognise that people's time is limited and therefore aim to use the summary document to meet their needs. The summary document includes details of where to obtain a copy of the larger document – and vice versa. Both include reference to copies on the CCG website.

We are targeting the distribution of the summary document to people who are most likely to be affected by the proposals. These are mainly the elderly and frail and people now in their late middle age.

We will therefore distribute the summary document via the following locations:

- Residential and nursing homes
- GP surgeries
- Community hospitals
- Pharmacies
- Churches and church halls
- Post offices
- Garden centres
- Acute hospitals
- Libraries
- Hairdressers
- Memory cafes
- British Legion
- Bingo halls
- Retirement villages
- Flyer distribution outside M&S, Lidl, Sainsbury, Tesco and other supermarkets

We will distribute copies of the *both* the summary and the full document to:

- GP surgeries
- Libraries
- Community and Acute hospitals
- Healthwatch
- Council offices
- Leisure centres
- Provider organisations with members (Foundation Trusts, GP practices etc.)

Social media

We expect huge social media interest.

We will use social media to:

- ***Listen*** to what people have to say
- To ensure we provide open, honest and transparent ***feedback*** and timely responses to questions posed
- Enable ***two-way dialogue*** in real time – for instance whilst events take place and questions arise (these will also be documented)
- To provide up-to-date ***information***

The nature of a consultation at this scale makes the driver for social media about breadth and depth. To provide as many channels as possible to encourage, promote and engage in meaningful conversations and dialogue with people.

Our key objective to ensure that everyone who wants to has the opportunity to have a say, have a voice. Not everyone can attend face-to-face meetings, pick up a phone or write a letter – however many have a spare ten minutes to send a tweet or post an Instagram pic. This type of resource is time efficient, can provide a level of anonymity (if required) and is in real-time.

We are calling our social media platforms digital rooms – these are essentially rooms online that enable and encourage conversations, feedback and information to be shared.

The aim of our digital room, is to;

- Build a community of people online to collect feedback and knowledge of our services across Devon
- To provide information, up-dates and feedback
- Enable engagement with the consultation in real time using online tools

- To engage with local online pressure groups to help discuss consultation information, particular topics or subjects and to correct any misinformation
- To provide specialist input if appropriate, for instance from our local clinicians

CCG employees, provider and social care staff should contact the communications team if they have any queries, questions or feedback on how they should use social media sites, or if they have any feedback on how the organisation should use its corporate sites.

The communications team are the guardians of the corporate sites and responsibility of those sits with them.

Tools

The digital rooms currently used by NEW Devon CCG include Twitter, Facebook, YouTube and our website.

Other channels that may be considered include – individual blog sites for clinicians, Instagram, snap chat – *this will be reviewed based on need.*

Voice

It is important that the messages, conversations and information provided is authentic and not deemed to be a corporate voice – otherwise it may appear contrived. Where this has worked well for other NHS organisations is when it feels like real people talking and engaging in conversations.

The CCG communications team will set up a hashtag and series of consultation specific sites where people can proactively contribute. This will highlight why they are involved in the consultation and the benefits locally that could be seen, examples and case studies (ensuring that nobody is mentioned who has not agreed) will support this type of activity. Twitter handle: #yourfuturecare

Messaging

Messaging – we will post questions, answer queries, provide useful information, keep an up-to-date track of events (including Q&As), stats or data – a general view of the consultation as it progresses.

The sites should provide information on events, dates, times and locations – where we can provide immediate responses we will. They should also be used as a way of keeping those who cannot attend meetings in a face-to-face capacity up to date with current thinking.

Proactive opportunities to promote our social media channels include;

- Consultation events
- Enquiries from people
- Promotion on websites and throughout all of our digital channels
- Through our key stakeholders
- Commissioners – GPs and wider health family

Reactive handling

Enquiries

Everyone will receive a response, when that can't be provided immediately a timeframe will be given as to when. Anything deemed a potential breach of patient confidentiality, is offensive or inappropriate will be discussed with the Governance team and managed off line. Enquiries, comments or requests that may be considered FOI will be handled as such with advice from the FOI officer.

Media

Any media outlets contacting us through social media sites will be directed through the usual press handling within the CCG communications team.

Addressing campaign groups

Where we can appropriately provide a clinician or other nominee to contribute to the social media group, where we can provide advice to provide clarification and avoid misinformation we will do so.

CCG social media contacts list – the communications team will endeavour to create a list of those clinicians and officers who are active on social media sites, that they use in a work capacity, or are willing to use during the consultation. This will leverage any opportunity for retweets, engagement and support for the consultation.

Website

The YFC website will be the main public repository of information. All communications will feature the address: www.newdevonccg.nhs.uk/about-us/your-future-care/102019

As a minimum it will contain:

- YFC full consultation document
- YFC summary consultation document (when ready)
- YFC consultation plan
- YFC consultation online questionnaire
- YFC consultation questionnaire (hard copy to download)
- YFC evidence file (when ready)
- YFC pre-consultation business case (PCBC)
- YFC newsletters
- Case for change
- Details of all consultation events
- Details of all engagement events
- Press releases
- Publications and related videos

Operational briefing

YFC operational briefing

All heads of communications across the NEW Devon CCG area have been invited to attend daily operational calls with the CCG.

These have been taking place since mid September and will continue throughout the consultation period.

The YFC operational group is supplemented by monthly communication and engagement strategy meetings, providing a link with Sustainability and Transformation Plan communications.

FOI operational group

FOI group receives information from the daily YFC operational communication group for coordination purposes only. Members link with PMO and providers to check veracity of information before release.

Operational communications group

All YFC operational communication activity (feeding channels) is coordinated through the CCG's operational communications group.

Launch plan

The plan below sets out key dates, decisions and actions required in the immediate lead up to and following the launch of consultation. The aim is to have one plan for the consultation that all parties can work to, to ensure effective coordination (booked roadshows appear in non-bold with more to add).

DATE	MEETINGS	CONSULTATION EVENTS (PUBLIC MEETINGS BOLD – ROADSHOWS NON-BOLD)	KEY DECISIONS / ACTIONS
w/c 3 Oct LAUNCH WEEK	• 6/10 – Clinical Cabinet • 7/10 East Devon District Council annual event –Hugo Swire MP or Neil Parish MP usually attend Angela Pedder speaking	• N/A – public meetings and road show events commence w/c 7 November	• 5/10 ○ Consultation document, response form and Freepost envelope go to print • 6/10 ○ Consultation website prepared for go live – includes consultation document, online response form, FAQs, contact us, list of public events ○ Reactive Q&A agreed ○ Media and social media plan agreed 7/10 ○ Consultation document distribution begins (hand delivered to libraries, council offices, community hospitals etc.). ○ Letter and consultation document emailed to key stakeholders – MPs, GP practices, Leagues of Friends, Scrutiny / Health & Wellbeing Boards, Healthwatch CEO / Chair, Community representatives ○ Consultation website goes live ○ Launch press release issued - spokespeople on hand. This will

			announce the programme of public meetings ○ Consultation posters distributed (GP practices, libraries, hospitals, pharmacies, supermarkets, leisure centres. Send to scrutiny contacts) ○ Consultation event plan put into action eg presentations, meetings, briefings roadshow, hard to hear focus groups, internal staff briefings etc. (NB: consultation log to be constantly updated capturing all meetings to evidence consultation) ○ Consultation response unit mobilised – log set up; mailbox monitored; team familiar with Q&As; standard holding responses agreed
w/c 10 Oct (Launch +1)	• 11/10 – North Devon PPG Network • 13/10 - PPEC	• N/A – public meetings and roadshow events commence w/c 7 November	• Finalise and publish summary document • Large print and audio versions etc. available • Preparation for events – banners, Q&As, speaker notes, equipment booking • Focus group events planning with OPM and Healthwatch • On-going media work – proactive media briefings to communicate key messages as well as monitoring and reactive responses • Working with partners to encourage people to respond to consultation document e.g. council news articles, etc.
w/c 17 Oct (Launch +2)	• 19/10 – Plymouth City Council Health and Wellbeing Board • 19/10 STP Strategic Engagement Forum • 20/10 - Clinical Cabinet • 21/10 – North Devon Community Representativ	• N/A – public meetings and roadshow events commence w/c 7 November	• Print banners • Brief public event speakers / facilitators • On-going proactive and reactive media, political and stakeholder relations

	es Network		
w/c 24 Oct (Launch +3)	• 27/10 - PPEC (informal) • Pop In events in Eastern locality	N/A – public meetings and roadshow events commence w/c 7 November	
w/c 31 Oct (Launch +4)	• 3/11 – CCG Governing Body • 3/11 - Clinical Cabinet • Pop In events in Eastern locality	N/A – public meetings and roadshow events commence w/c 7 November	
w/c 7 Nov (Launch +5)	• 8/11 – Devon Health and Wellbeing Scrutiny Committee • Pop In events in Eastern locality	• 7 November – Knowle, Sidmouth 1300-1530 and 1730-2000 • 8 November – Ocean, Exmouth 1330-1600 • 10 November – Beehive, Honiton 1000-1230	• Events support and staffing • On-going proactive and reactive media, political and stakeholder relations
w/c 14 Nov (Launch +6)	• 15/11 – Devon Parent Carer Voice (Buckfast) • 17/11 - Clinical Cabinet	• 14 November – New Hall, Tiverton 1000-1230 and 1330-1600 • 16 November – Charter Hall, Okehampton 1400-1630 and 1700-1930 • 18 November – Whipton Community Hall, Exeter 1430-1700	• Events support and staffing • On-going proactive and reactive media, political and stakeholder relations
w/c 21 Nov (Launch +7)	• 23/11 – Plymouth Wellbeing Overview and Scrutiny Committee	• 21 November – St Lukes College, Exeter 1800-2000 • 22 November – Exmouth College 1730-2000 • 24 November – Gateway, Seaton 1400-1630 and 1730-2000	• Events support and staffing • On-going proactive and reactive media, political and stakeholder relations
w/c 28 Nov (Launch +8)	• 29/11 - Devon Parent Carer	• 29 November – Beehive, Honiton	• Events support and staffing • On-going proactive and reactive

	• Voice (Barnstaple) • 1/12 - Clinical Cabinet	1200-1430 • Roadshow dates to be confirmed	media, political and stakeholder relations
w/c 5 Dec (Launch +9)		• Roadshow dates to be confirmed	
w/c 12 Dec (Launch +10)	• 13/12 – Joint Engagement Board • 15/12 - Clinical Cabinet	• Roadshow dates to be confirmed	
w/c 19 Dec (Launch +11)	•	• Roadshow dates to be confirmed	
w/c 26 Dec (Launch +12)	• 29/12 - Clinical Cabinet		
w/c 2 Jan (Launch +13)	• 05/01/17 – CCG Governing Body		

Media plan

The draft consultation document was published on 21 September for the Governing Body meeting on 28 September prompting a wave of initial local media coverage.

Proactive coverage was sought and achieved in key media (including BBC Spotlight, ITV and the Western Morning News) and we continue to target key media.

We will work with media looking at challenges in the NHS, working with heads of communications to coordinate and organise case studies etc.

Launch

Given the backdrop of the GB decision and heightened media around this, the plan for the 'launch' of the consultation is relatively low key from a media perspective, consisting of a press release confirming consultation launch issued to key titles. This will also list the public meetings that will take place during the 13-week consultation period. Media interviews will also be offered.

Clinicians will act as lead spokesperson for broadcast and print media to promote New Models of Care.

A rolling reactive Q&A has been agreed for use to guide responses to enquiries and this will continue to be updated throughout the consultation period as new questions come in.

Proactive

Our proactive approach falls into five distinct phases:

1) Pre-launch and immediate post launch: Focus on case for change and drivers
2) Post launch: Focus on advertising events and options
3) From start of events: Promotion of case studies in support of the model of care
4) Towards end of consultation: Continued promotion of case studies in support of the model of care with encouragement to have say before deadline
5) Post consultation: Focus on next steps and decision-making

Approach

The media approach during consultation will be as follows:

News media will be kept informed with press releases and interviews provided as appropriate.

Media enquiries will be handled as swiftly and accurately as possible, with inaccuracies challenged and rebutted, based on a set of agreed and updated Q&As.

Media protocol in place; all media enquiries about YFC to be sent to the CCG communication team for a response.

A daily news digest of coverage is sent daily to CCG staff with open invitation to provider staff circulated via heads of communications

Local newspaper adverts may be considered as a way of providing information about consultation and engagement events should local coverage (and poster information) need to be bolstered.

Press releases can be found here.

Media training

Media training is on-going and so far a range of clinicians have been trained in a programme that will continue through the early phase of consultation.

Author: Nick Pearson, Head of Communications
Executive Lead: Janet Fitzgerald, Director of Corporate Affairs
25th October 2016

Appendix 1: Flyer for public events

‘Your Future Care’ consultation

NHS

Your future care

NHS Northern, Eastern and Western Devon Clinical Commissioning Group is working to improve your future care by:

- **Providing more care in people’s homes**
- **Avoiding hospital admissions where possible**

As part of this work, we are running a **13-week consultation on the best places for community hospital beds in Eastern Devon**

Register now to guarantee a place at one of our **public meetings**

Date	Time	Location
Monday 7 November	13.00 – 15.30	East Devon District Council, The Knowle, Station Road, **Sidmouth**, EX10 8HL
Monday 7 November	17.30 – 20.00	East Devon District Council, The Knowle, Station Road, **Sidmouth**, EX10 8HL
Tuesday 8 November	13.30 – 16.00	Ocean, Queens Drive, **Exmouth**, EX8 2AY
Thursday 10 November	10.00 – 12.30	The Beehive, Dowell Street, **Honiton**, EX14 1LZ
Monday 14 November	10.00 – 12.30	New Hall, Barrington Street, **Tiverton**, EX16 6QP
Monday 14 November	13.30 – 16.00	New Hall, Barrington Street, **Tiverton**, EX16 6QP
Wednesday 16 November	14.00 – 16.30	Town Hall, Fore Street, **Okehampton**, EX20 1AA
Wednesday 16 November	17.00 – 19.30	Town Hall, Fore Street, **Okehampton**, EX20 1AA
Friday 18 November	14.30 – 17.00	Whipton Community Hall, Pinhoe Road, **Exeter**, EX4 8AD
Monday 21 November	18.00 – 20.00	St Luke’s Science and Sport College, Harts Lane, **Exeter**, EX1 3RD
Tuesday 22 November	17.30 – 20.00	Exmouth Community College, Green Close, **Exmouth**, EX8 3PZ (Main Hall at the Green Close site)
Thursday 24 November	14.00 – 16.30	Town Hall, Fore Street, **Seaton**, EX12 2LD
Thursday 24 November	17.30 – 20.00	Town Hall, Fore Street, **Seaton**, EX12 2LD
Tuesday 29 November	12.00 – 14.30	The Beehive, Dowell Street, **Honiton**, EX14 1LZ

Please register to guarantee your place.

Call **01392 356 084** or email **d-ccg.YourFutureCare@nhs.net**

Where there is demand, further meetings will be organised.

Co-Location of Stroke Services in Northern Devon

PH/16/xx
Health and Wellbeing Scrutiny Committee
8 November 2016

REPORT TO: Devon Health and Wellbeing Scrutiny Committee

DATE: 2 September 2016

PRESENTED BY: Alison Diamond

1. Introduction

This briefing paper outlines Northern Devon Healthcare NHS Trust (NDHT)'s proposal to co-locate acute and rehabilitation stroke services at North Devon District Hospital (NDDH).

NDHT believes that there is a strong clinical case for change in favour of bringing the Stroke Rehabilitation Unit to NDDH, and co-location of stroke services will deliver a number of benefits to patients and the Trust.

The Trust believes that it is not necessary to carry out a formal consultation on these proposals for the following reasons:

- There are no other viable options than the one proposed
- This does not constitute significant service change – the services are remaining, only their location is changing

2. Case for Change

2.1 Clinical

Assessment of the current stroke service in Northern Devon

Stroke patients in North Devon are generally admitted directly to the Acute Stroke Unit (ASU) at NDDH for the acute spell of their stay and are then either discharged under Early Supported Discharge (ESD) or transferred to the Community Stroke Rehabilitation Unit (12 bed unit at Bideford Community Hospital - SRU) for further specialist rehabilitation.

Due to the geographical challenges of North Devon some patients (living Barnstaple and Eastwards) do not find Bideford convenient and choose to be transferred from ASU to an alternative community hospital of their choice, closer to where they live. This means that they do not have access to specialist stroke rehabilitation services. It also impacts on the Trust's ability to achieve the national stroke Integrated Performance Measures (IPMR) target of 80% of patients achieving 90% of their stay in a dedicated Stroke facility. Transferring the patient to Elizabeth ward also adds a delay into the process, as the patient is fully re-assessed on arrival.

The Stroke Early Supported Discharge service (ESD) has been up and running since November 2010 and has been nominated for several awards. The purpose of the Early Supported Discharge Team is to enable appropriate stroke patients to return home sooner with specialist stroke therapy delivered at home for up to six weeks. The ESD team consists of physiotherapists, occupational therapists, therapy support workers and speech and language therapists.

Patients are currently discharged into this service from ASU or Bideford if they meet the criteria for the ESD programme. The success of the ESD scheme means more complex patients are admitted to Bideford and this is causing the clinical team difficulty in overseeing stroke patients on two sites.

The stroke service has had difficulties in consistently delivering against a number of stroke performance indicators including the 90% stay on a Stroke Unit and direct admission to a stroke unit targets.

Performance in 2015/2016 against national targets:

- 90% of patients should be admitted to a specialist stroke unit (acute) within 4 hours. In 2015-16 we achieved 55%.
- 80% of patients should spend 90% of their stay on a specialist stroke unit. In 2015-16 we achieved 77%.

Research has shown that stroke patients treated on a stroke unit do better than those treated on medical wards or general assessment units. Patients are more likely to survive the stroke, have fewer disabilities and be able to live independently if treated on a stroke unit. Evidence shows that it is really important that patients get admitted to a stroke unit early because they get access to the right specialist clinicians and get the right treatment more quickly – both crucial with strokes.

Direct admission to a stroke unit also means we are more likely to meet other quality targets, i.e. % of patients scanned within 24 hours of hospital arrival and receiving a swallow assessment within 24 hours of admission. The stroke specialist staff working in ASU ensure that these are undertaken and have the necessary training and competencies.

It is really important that we offer a stroke service to the population of Northern Devon that has the capacity and capability to deliver high quality care.

It is our proposal to bring the Stroke Rehabilitation Unit to NDDH as this will create a more cohesive stroke clinical team to ensure every patient gets onto a stroke ward and receives the specialist care they need.

NHS Improvement: Stroke Improvement Clinical Associate visit

In 2012 we asked NHS Improvement Stroke Improvement Programme to review our acute stroke pathway and make recommendations as to where improvements could be made that would improve performance and provide clinical care that met national standards. A number of recommendations were made and the report acknowledged that many of the solutions proposed locally were dependent on the proposed co-location of the stroke rehabilitation unit into a single site at Barnstaple.

Stroke Association consultation on NEW Devon CCG stroke services in eastern Devon

NEW Devon Clinical Commissioning Group and the Stroke Association conducted a consultation in 2013 about the future configuration and specification of community stroke rehabilitation services in the eastern locality. The aim was to ensure services delivered the greatest benefit to patients taking into account recent developments in stroke care.

An outcome of the consultation was that consolidation of the community rehabilitation units should take place to bring specialist stroke clinicians together, improve resilience of the team and further enhance the quality of rehabilitation offered to stroke patients following an admission to the Royal Devon & Exeter hospital (RD&E).

As a result, the merger took place of the Exmouth and Crediton community rehabilitation units into Ottery St Mary Hospital at the end of 2014. This was the first phase of a plan to deliver an integrated stroke service with co-location with the acute service at the RD&E being the preferred future solution.

3. Proposed stroke pathway - main benefits to patients and stroke clinicians

The proposed stroke pathway will deliver a seamless transition of care for all stroke patients.

We know that stroke patients have better outcomes if they are treated in a specialist stroke setting and by co-locating stroke services at NDDH we envisage that there will be a reduced number of patients choosing to transfer to non-stroke community hospitals.

Co-location of acute and rehabilitation stroke services at NDDH will provide a greater ability to flex between acute and rehabilitation beds to ensure that all stroke patients are cared for in a stroke bed.

There would also be the potential to further embed and develop the ESD service, which could further reduce the length of stay.

We also believe that the proposals will deliver improved efficiency and continuity of discharge planning and family liaison.

This proposal will also deliver an improved pathway for patients who are medically unwell on the SRU. Currently they come back to NDDH via the Emergency Department and usually to the Medical Assessment Unit before transferring back to Bideford. If they were co-located to the ASU a single, multidisciplinary, team would provide seamless care.

The proposals will deliver an improved and refurbished clinical space on the NDDH site and a number of workforce benefits including:

- Reduced pay costs by more efficient use of skilled staff resource.
- Efficient use of dedicated social services case manager for the combined stroke unit
- Opportunity for clinical support workers in therapy and nursing to work generically to ensure 24 hour/7 day per week approach to rehabilitation

Further anticipated benefits are detailed below:

Patient Experience

- Patients will be familiar with staff who will be working across the whole unit.
- Access to specialist stroke medical input 5 days a week for both the ASU and SRU
- Potential for earlier discharge due to benefits of the combined units and the ESD service

- NDDH is potentially more accessible for many relatives with better public transport routes when compared to Bideford
- This could give an opportunity for improved management of the growing cohort of Neurological Rehabilitation patients, as the clinical skills and knowledge of the Stroke Rehabilitation Team are transferable to patients with Acquired Head Injury who currently receive their care outside of North Devon. This would be dependent on commissioning intentions.

Nursing

- Opportunity to utilise staff with stroke skills across both areas
- Staff will have the opportunity to be developed with both acute and rehabilitation skills resulting in a multi-skilled stroke nursing workforce who can rotate through the units
- A flexible workforce which can attract external applicants and support succession planning
- Less time would be spent by trained staff and ward clerks organising discharges to SRU (normally involves faxing letters, phone calls, transport, pharmacy, discharge summaries, etc.) which will be replaced with a verbal handover.

Occupational and Physiotherapy

- Improved flexibility and ability to cover absences due to a larger pool of staff, therefore reducing the impact on patient care and potential delays in length of stay
- Improved skill mix
- Equitable and timely access to the hydrotherapy pool for all stroke patients
- Equitable access to therapy equipment on one site
- Streamlined patient journey as no additional reassessment required by SRU staff

Speech and Language Therapy

- Reduced staff travel costs
- Enable more efficient co-ordination of support operating from a collocated rehab and acute unit.
- Improved flexibility and ability to cover absences therefore reducing the impact of patients care and potential delays in length of stay
- Opportunities for better training and sharing of skills and resources

Medical Staffing

- 24 hour medical cover on site for stroke rehabilitation patients
- Increased stroke specialist input for stroke rehabilitation patients
- Increased number of ward rounds on the combined unit
- There would be a dedicated associate specialist for the acute and rehabilitation service on site at NDDH 5 days per week, improving access to this specialist care

Dietetics

- Dietetic attendance at stroke MDTs
- Earlier and more timely dietetic patient assessments
- Improved dietetic cover and a more flexible service.

Further opportunities for the Trust

The co-location of the SRU with the ASU also offers a number of wider benefits to the Trust as follows:

- Potential to ring-fence stroke beds
- Ability to rectify the general lack of therapy space within the organisation
- To provide an appropriate location for the care of younger patients with head injury who require Neurorehabilitation services within the Trust
- To refurbish and upgrade another clinical space at NDDH in line with the Trust Estates Strategy
- Ability to provide a 7-day therapy service

4. Impacts

Access to services

Having the SRU based in Bideford means that patients from North Devon who have a stroke and require the SRU are significantly disadvantaged compared to those who live in Torridge as they have much further to travel to reach the SRU.

Many patients from North Devon chose not to go to the SRU because it is so far from their home and visiting relatives (see patient story). This means that they do not get access to the specialist stroke services they need to improve their recovery.

A health inequality is therefore developing whereby patients in North Devon do not recover as well from a stroke as patients in Torridge because of the current location of the SRU.

NDDH, in Barnstaple is geographically in between Torridge and North Devon and has the best transport links to both areas. Therefore co-locating the stroke services will ensure more equitable access to this service for patients across Northern Devon.

Workforce impacts

Relocating the stroke rehab ward to NDDH will have an impact on members of staff who are based in Bideford. Some of these people have already experienced changes to their working conditions, some having moved from Torrington and some having subsequently moved from Willow Ward to Elizabeth Ward. There are some staff, particularly hotel services, who may find it difficult to relocate due to transport difficulties.

The relocation of staff is always something which we sensitively work through with HR, management and staff side on an individual basis. The Trust would work with all staff members, and their representatives, to secure the best employment options.

Staff engagement meetings are planned and as soon as there is a decision with regards to the co-location of stroke services, a formal HR consultation process would be carried out.

Impact of beds on NDDH

There have been significant improvements in patient flow at NDDH thanks to the embedding of the perfect week methodologies within the Trust. The Trust is currently engaging with clinicians and other members of staff at NDDH to discuss the future ward configuration at

NDDH. Meetings are planned for 2 September and 20 October. In these meetings, staff will discuss the priorities that need to be addressed immediately, particularly around the co-location of stroke services, and how we can improve patient flow so that patients get to the right place first time. The Divisional Management team will be gathering views on how some of the wards within the hospital could be best used to address these priorities.

5. External engagement plan

The Trust will not be carrying out a formal consultation on these proposals for the following reasons:

- There are no other viable options than the one proposed
- This does not constitute significant service change – the services are remaining, only their location is changing

5.1 Objectives

- To work in partnership with communities across Northern Devon to understand the impact of the co-location of stroke services to NDDH for patients and the public.
- To ensure key stakeholders, patients and the public understand reasons for the co-location (see case for change above)
- To understand any impact (positive and negative) of the co-location for staff, patients and the public across Northern Devon
- To ensure key stakeholders, patients and the public have the opportunity to discuss the impact that the co-location will have on Bideford hospital.

5.2 Communications and engagement key messages

1. More equitable access to services for patients across Northern Devon
2. Clinically it is better for patients – people will recover better from a stroke
3. Thanks to improved patient flow, we can use the beds at NDDH differently. We will be working with staff to determine the location of the SRU at NDDH
4. Explaining why we are not doing a formal consultation

5.3 Delivering the objectives

Meetings with key stakeholders and the public

We will hold a series of meetings and events to provide an opportunity for:

1) The Trust to share the rationale for the co-location
2) Patients, public and stakeholders to gain reassurance about concerns they may have regarding the co-location
3) Patients, public and stakeholders to feedback on how the co-location might impact them
4) Discuss the impact on Bideford community hospital

Key stakeholders include:

- NEW Devon Clinical Commissioning Group
- Health and Wellbeing Scrutiny Committee
- Torridge District Council
- North Devon District Council

- GP forum
- Stroke group - Torridge
- Stroke group - North Devon

Questionnaire

We will also be requesting feedback via a questionnaire about this co-location for those who cannot or do not wish to attend a meeting. This will be available in hard copy and online.

5.4 Timeline

Week one	announce – publish the engagement doc, publish online survey
Week two	meetings reminder
Week three	meetings reminder
Week four	meeting in Torridge
Week five	meetings in North Devon
Week six	IPSG
Week seven	Develop mitigation – internal
Week eight	announce 'you said we did'

6. Conclusion

It is important that we offer a stroke service to the population of northern Devon that has the capacity and capability to deliver high quality care.

The Trust believes that there is a strong argument in favour of bringing the Stroke Rehabilitation Unit to NDDH as this will create a more cohesive stroke clinical team and will ensure every patient gets onto a stroke ward and receives the specialist care they need.

The Trust further believes that the engagement process detailed above will ensure that key stakeholders, staff, patients and the public understand the reasons for the co-location and understand the impacts that this change will have.

Report to Devon Health and Wellbeing Scrutiny Committee 8th November 2016

NHS 111 and Out Of Hour's Service (Integrated Urgent Care Services) For Devon

Recommendation

It is recommended that the Committee:

- Notes the report and progress with the introduction of the new Integrated Urgent Care Services
- Receives a 12 month review and evaluation report in November 2017, with an interim 6 month update should this be required

1. Purpose of the Paper

This paper is provided to Devon Health and Wellbeing Scrutiny Committee to:

- Update the Committee on the new service model for NHS 111 and Out of Hours care for Devon now known as the Integrated Urgent Care Services (IUCS).

- Provide early feedback on implementation of the Integrated Urgent Care Services since the go live date of 1st October 2016 and an outline of how this new service will be evaluated.

2. The Integrated Urgent Care Services Model

Procurement for both NHS 111 services and Out of Hours services was affected by new national guidance received in July 2015. This guidance published by NHS England gave CCGs across the country clear instructions about the commissioning of NHS 111 and Out of Hours services in an integrated way, rather than as separate services. The ambition was to achieve Integrated Urgent Care Services (IUCS).

The Clinical Commissioning Groups (CCG's) in Devon – both NEW Devon CCG and South Devon and Torbay CCG - needed to procure a new service. The NHS 111 provider, South Western Ambulance Services Foundation Trust (SWASFT), had given notice on this contract in advance of the termination date and was having difficulties achieving the performance standards. The

Out of Hours service in Devon, run by Devon Doctors Ltd, was a high performing service, but had not been market tested as an NHS 111 provider and urgent care is an area of high procurement interest.

Procurement of the new model for NHS 111 and Out of Hours service commenced in December 2015 and the commissioners have now agreed a contract with Devon Doctors Ltd for the whole service. Devon Doctors is working with a subcontracted partner, Vocare, who have a proven record of being a NHS 111 provider to deliver the NHS 111 telephony component of the service. This contract commenced on the 1st October 2016. The contract value is circa £45 million for three years with the possibility of a further two years extension.

This new integrated service provides a telephone service for the public looking for advice and help to find the most appropriate place or source of urgent treatment. It is designed to encourage people to call in advance wherever possible to receive advice rather than turn to emergency department and 999 services unnecessarily. There are many options available to patients which are closer to home and often more suitable for their needs. This new call and advice service is now combined with the Out of Hours medical service which provides urgent primary care (GP) cover outside of normal General Practice hours.

The IUCS is designed to bring considerable benefits to patients. The key benefits can be highlighted as:

- Improved call answering response time for patients.
- Greater proportion of calls answered receiving clinical input.
- Automatic offer of appointments for under one year olds, and automatic clinical involvement for under-fives and over 85's.
- Booked, timed appointments for those who need to be seen.
- Where at all possible, no one having to travel more than 30 minutes to a treatment centre to see a GP face to face.
- Where required, an immediate offer of an appointment and reduced overall call answering time.
- Immediate 'through call' for people who know what they need (e.g. dental advice).

One key aspect of the service model is the Out of Hours treatment centre where patients visit to see a GP if necessary. Review of the previous arrangements showed:

- The perception that treatment centres are available for people to 'drop in' is not correct. The service either cares for people over the phone (circa 60% of all calls), visits the person at home (15%) or asks them to attend at treatment centre (25%). This remains the design in the new IUCS.

- The numbers of people seen are considerably smaller than may be imagined but where people need to be seen it was decided, where at

all possible, to maintain a ’30 minute’ rule meaning in the IUCS no-one should have to travel more than 30 minutes to see a GP face to face in an Out of Hours treatment centre,

Previously Devon had a higher number of treatment centres when compared to other CCG’s. The procurement therefore included a signal that the new provider could seek to reduce the number of treatment centres whilst, where possible, maintaining a ’30 minute’ rule. As part of the changes, some treatment centres have now been closed (Tavistock, Exmouth, Holsworthy, Paignton, Bideford and Dawlish), with the small numbers of patients who would have used these either being seen at home or going to other treatment centres.

This service model had the support of both CCGs as meeting the needs of the population and making best use of resources. There are a couple of very distinct locations where the 30 minute rule is challenging but this has been discussed, and further mitigation has been included, such as a greater offer of choice for those individuals. For example the North Devon Coast (patients in the Hartland area can choose to go to Barnstaple or Stratton and for Lynton, can go to Barnstaple or consider Minehead as well). This is possible through agreements with neighbouring Out of Hours services.

3. Patient and Public Involvement

Throughout the development of the specification and the procurement process, every effort was made to understand the impact on service users and to involve them in both the designing of the service and selection of a provider for the service. The engagement process included:

- Gathering information about what people felt was important to take into account when designing this and wider community services.
- Involving public representatives in the design of the Out of Hours service specification setting out the requirements of the future service.
- Involving public representatives in the procurement process for the integrated Out of Hours and NHS 111 service.
- Communicating with the public on the resulting changes to the service following procurement.

It is intended that there will be ongoing involvement of patient and public representatives in the monitoring and evaluation of the new Integrated Urgent Care Service (IUCS).

Additionally, in order to assure the CCGs and the public that all possible impacts had been considered and either eliminated or managed, an Equality Impact Assessment was carried out. Overall there were positive impacts in clinical safety, patient experience, and effectiveness. Some protected and other groups were identified as needing greater consideration in the planning

of the service and the mitigation for this was included, for example training and support for call handlers dealing with people who have difficulty using telephone based service.

Rurally isolated people were identified as possible group who could be disadvantaged by the location of the centres but this was mitigated in three ways:

- Continued ability to use all sites to rendezvous with people,
- The use of increased telephone based clinical advice could reduce the need to travel to be seen.
- The increase in home visiting would benefit this group.

4. Implications of the changes

In summary, in reviewing the model the following points became clear:

- There are no negative changes at all in the way the public can make contact with the service. As previously, people can ring NHS 111 and speak to a call advisor who will help to source the right care for them. At the current time approximately 7,450 people ring the service every week.

- There is a positive change for people who know what they need. The call response allows some groups of people, for example palliative care patients, to go directly to the end solution and thus reduce their call time. This is a total of 1,930 per week of the 7,450 people who call the service.

- For people who need a home visit there is increased clinical capacity available to offer these visits. Separation of the visiting element of the service from the treatment centres cover enables better planning and predictability. This is a total of 479 people per week of the 7,450 calls.

For the 1,038 treatment centre visits needed per week it was estimated that with the closure of some treatment centres there would be a direct negative impact on approximately 36 people a week who would have to travel further than they do now. About 130 people per week would be affected across the whole of Devon but this higher number has been offset as Devon Doctors Ltd has increased their home visiting service for those people who are unable to reach the new centre. Additionally for those people living close to border there is the option of being offered an appointment in neighbouring counties if this was more convenient for example Launceston, Stratton, Minehead and Taunton.

However we have been mindful of the possible consequences of the changes:

- The change may be amplified by other changes in the wider system of community care so that patients feel they a 'losing' buildings that currently provide services from their community.

- The difference between a minor injury service and a treatment centre is not understood. Treatment centres are essentially an 'Urgent Out-of-Hours GP Surgery' which people are directed to and a minor injury unit is a centre (usually nurse led) where people can choose to present themselves.

- The change in the model of GP's working across the county led to a perception that clinical levels were reduced but this is not the case. The level of medical input into the NHS111 and out of hour's service is consistent with the previous service.

- A number of services which were not commissioned were exposed in this procurement and separate arrangements have been put in place to address these for a further period of time whilst discussions continue between the CCG and providers.

4. Ongoing Review, Evaluation and Early Feedback

There is considerable national interest in the new service model and this will continue as the service changes and evolves. As part of the national Urgent Care Vanguard Programme, South Devon and Torbay CCG has access to national training & evaluation opportunities that will benefit the service.

Locally, the newly mobilised phase warrants several review calls per week and this will reduce over time as performance increases and confidence in the new service grows. There is a very comprehensive clinical governance process which monitors the quality, safety and clinical model of care that is being provided and then separate contractual monitoring which reviews the perfomance of the new service.

As a minimum the CCGs expect delivery of the key performance metrics, but will be considering very rapidly how to encourage people to use the NHS 111 service to inform their choice of urgent care as well as considering how the clinical element of the service can be enhanced to provide more advice and support to community colleagues and people with specific clinical needs.

Both aspects of the review process will include members of the public who will participate in the process. Additionally the provider is setting up a patient participation group for the service and the CCGs will be reporting to their own Patient and Public Engagement Groups in relation to the new model. Already feedback is shaping the service model; for example, the front end message is shortly to be reviewed by a group of people to simplify it.

The new service model went live on the 1st of October and is performing well; weekday performance for the NHS 111 service is over 85% of calls answered in 60 seconds which is good at this stage in a service with a high proportion of newly trained staff. Weekend performance is not quite so high (circa 70-80%) but the abandonment rate (people ringing off before their call is answered) is much lower than has been previously experienced as calls are being answered more quickly. This is in line with the call answering trajectory we would expect of a new service of this nature whilst working to understand true demand on the service.

Feedback received to date also indicates:

- People like the booked and guaranteed appointment time to be seen.
- The ability to agree the timing for those appointments is welcomed and has helped with travelling arrangements.
- Callers appear to appreciate the ability to speak with a clinician to provide support and advice over the phone more frequently.
- The offer of an appointment to under one year olds as provided assurance to parents.
- The care homes line which is part of the service is particularly well used by care homes, staff seeking and advice.

5. Next steps

The service is newly established and will continue to be monitored and evaluated using a comprehensive range of national and local indicators which help us to understand the whole service model. Metrics review the technical call handling process, quantity of calls and response times, the clinical quality and safety of the service as well as the impact of this service on other urgent care providers in Devon. It is proposed that a review and evaluation report is provided to the Health and Wellbeing Committee after 12 months of operation, with an interim report after 6 months if the Committee requires this.

Presented by:

Dr Justin Geddes: CEO Devon Doctors Ltd
Annette Hammett: Director of Operations Devon Doctors.
Elaine Fitzsimmons: Associate for NEW Devon CCG and South Devon & Torbay CCG