NHS

YOUR FUTURE CARE

Consultation Document

Consultation from 7 October 2016 to 6 January 2017

Your future care

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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 دووڵ مەلە 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 পেতে চাইলে **01392 267 680** ননম্বরে আমাদের সাথে যোগাযোগ করতে দ্বিধা করবেন না।

Arabic

اذا كنت تريد الحصول على نسخة بطريقة أخرى أو بكتابة المنشور بلغات أخرى 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

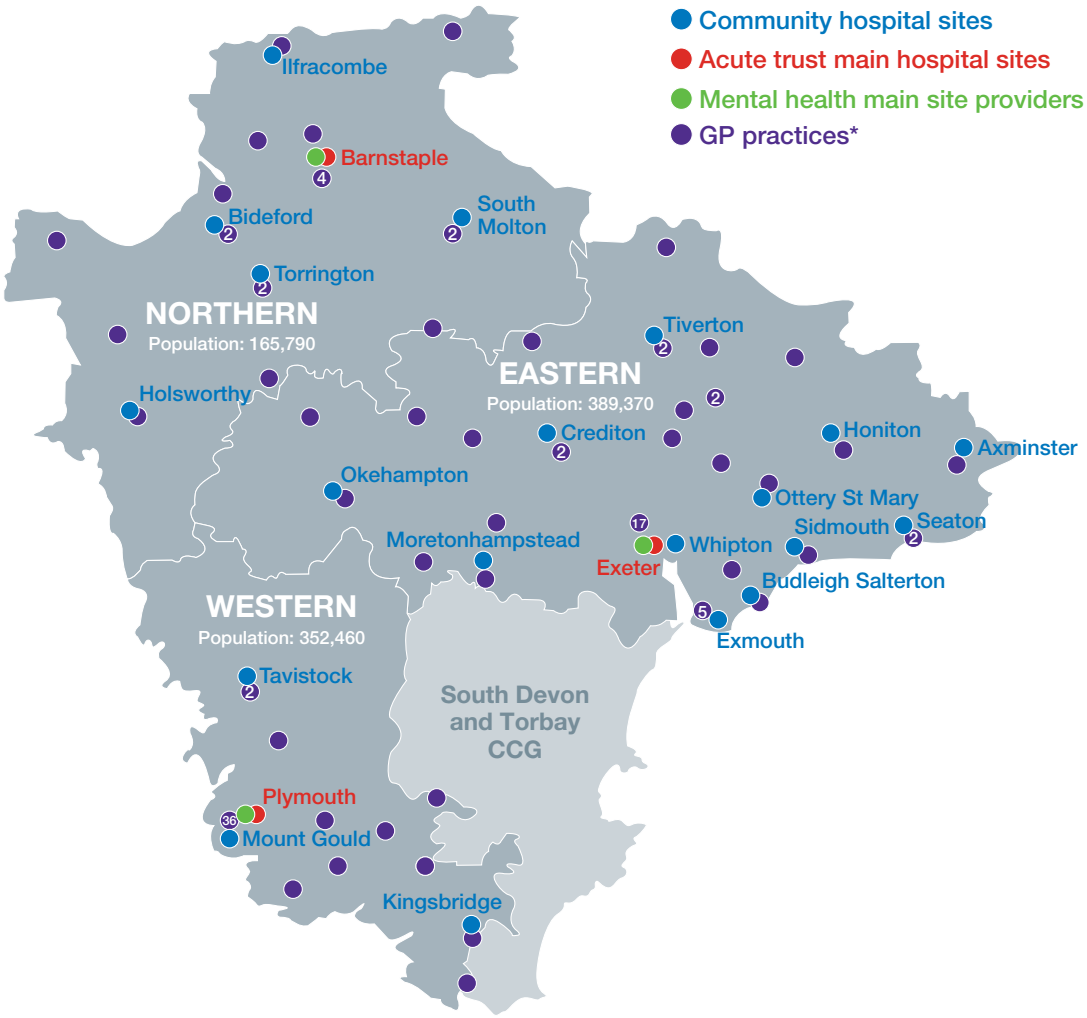
1 Your local NHS

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.

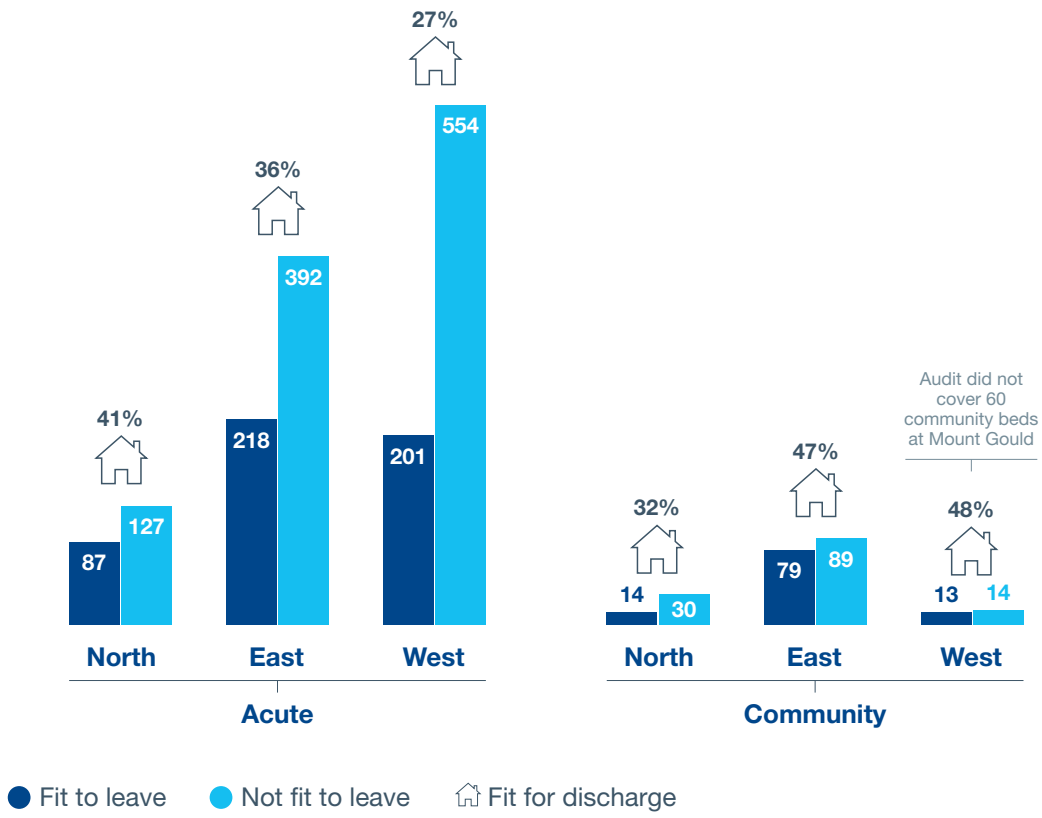
The National Picture

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.

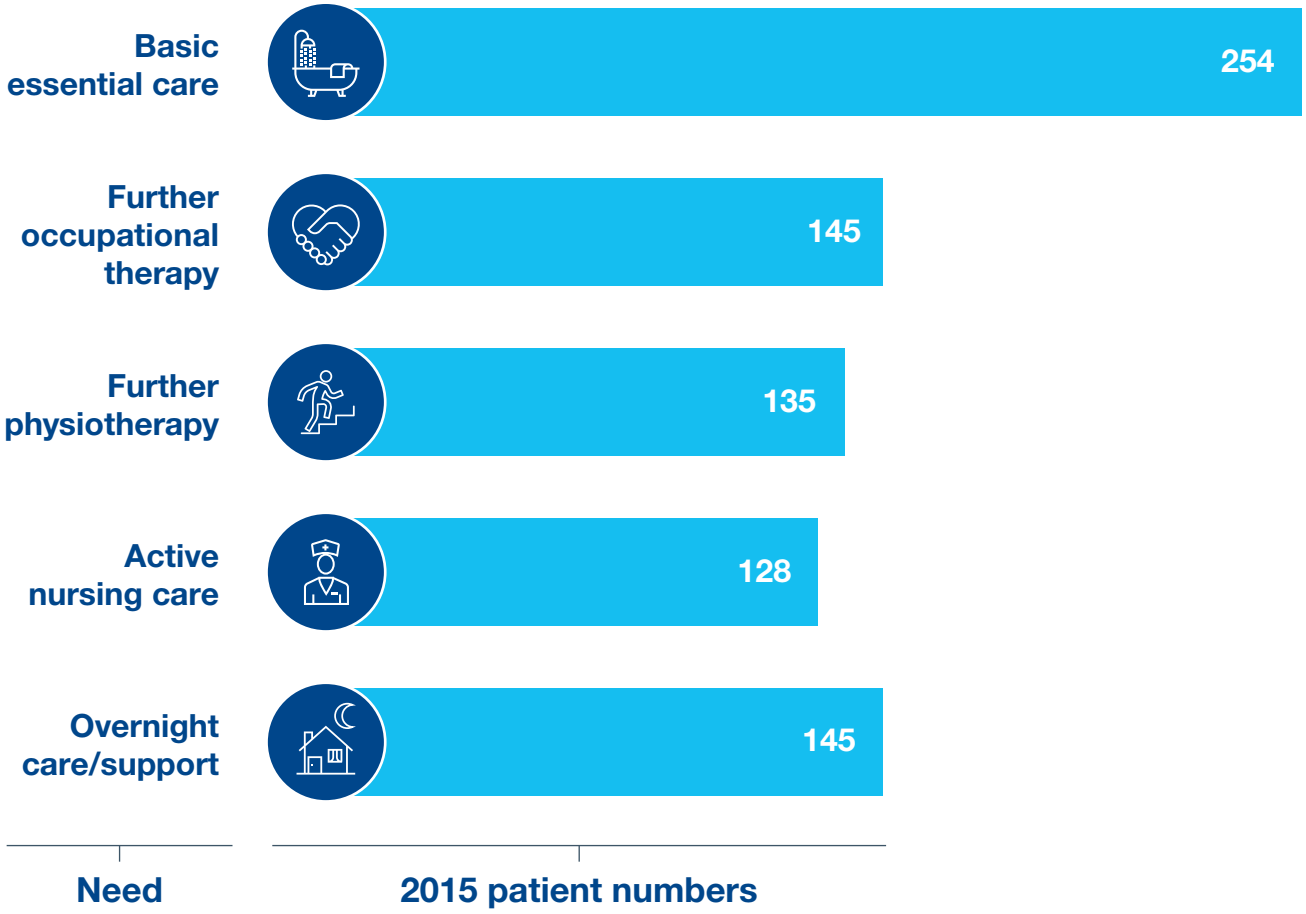
The NHS nationally has a five-year plan launched in 2014 called the **Five Year Forward View**. This sets out the direction for the NHS over the next five years and areas to focus attention for change to deliver the objectives set by Government for the NHS. The Five Year Forward View includes important 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.

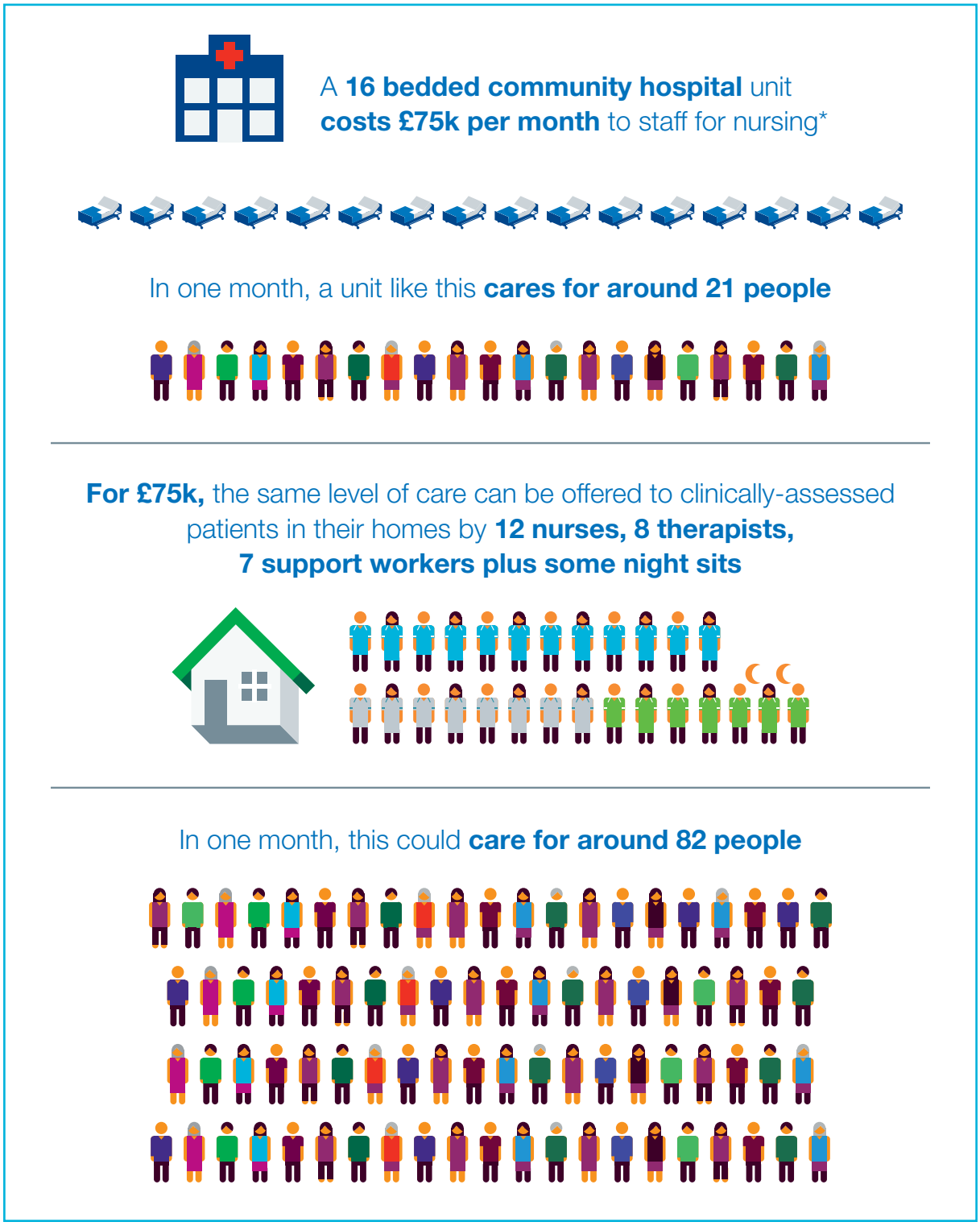
A graph showing the number of people who were in hospital beds who could have been cared for elsewhere, during an audit in NEW Devon in October 2015.



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.

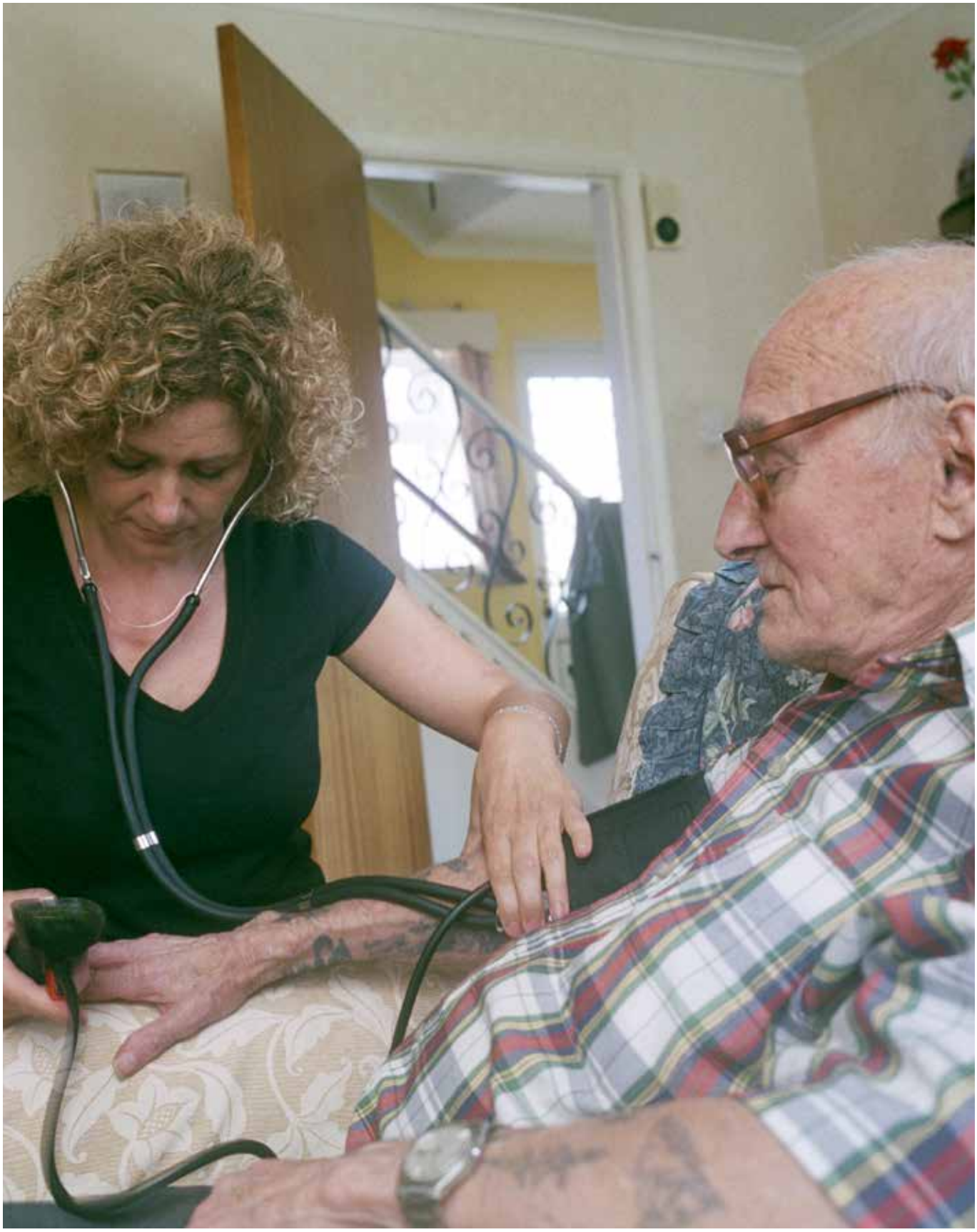
Experience in Northern Devon indicates implementing the new model of care has not created additional work for our already hard-pressed primary care teams. Further work will be undertaken to confirm this is the case across the NEW Devon area and as implementation plans are developed our primary care workforce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

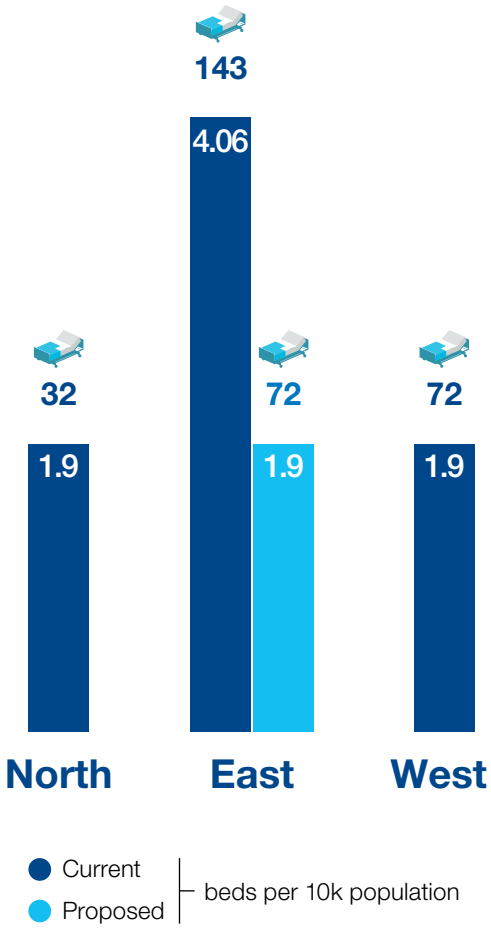
Options	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
32 bed unit	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton	Tiverton
24 bed unit	Seaton	Seaton	Seaton	Seaton	Seaton	Exmouth	Exmouth	Exmouth
16 bed unit	Sidmouth	Honiton	Exmouth	Exeter	Okehamp-ton	Sidmouth	Honiton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

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.

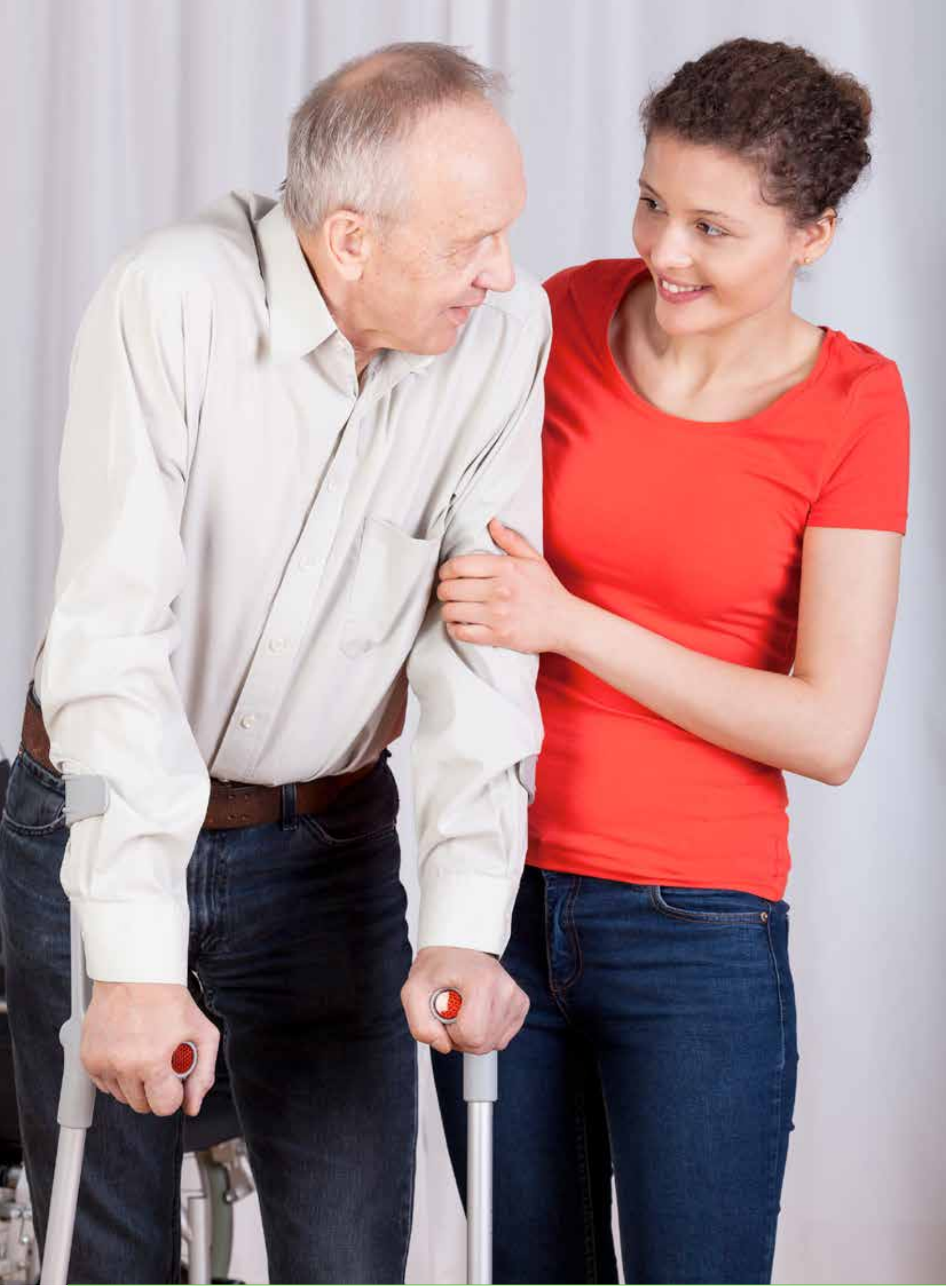
The building works to convert Exmouth's two current wards to a single 24-bed ward would cost up to £1.2m and take up to 18 months to complete – leading to temporary disruption to hospital services and delaying our ability to improve care for our patients. Options with Exmouth as a 24-bed hospital therefore 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

NHS

Contact us

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