HEALTHY PEOPLE
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Northern Devon

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

How many community hospital beds do we need for the future?

Executive summary

The developmental work we have undertaken, including the test of change in Torrington, combined with national information, suggests that more care can be offered in people's own homes than is currently provided. The evidence [1] suggests that the outcomes for people are safe and good, and a clear message we took from our engagement with the community last year was that more people wanted to remain in their own homes whenever possible.

People indicated they wanted more community services to prevent deterioration in health, maintain independence, provide care when ill, and support them to recover. This matches our need as a Clinical Commissioning Group (CCG) to meet the changing requirements of our population as well, as people are living longer with more complex disease than was previously the case. This leads to greater demand for more services.

We are very keen to treat as many people as we can in home based care settings where it is safe to do so. Our local provider, Northern Devon Healthcare Trust (NDHT) is responsible for community based health and social care services which are well received by patients. We want to increase the availability of more community based services to offer safe and good quality care in the home and community. To do this we need to find the resource, both funding and staff, to be able to offer a consistently good quality service in the long term.

We know that there is a need for community hospital beds and they will need to have more intensive staffing than previously provided to meet the clinical needs of patients. We believe the balance between bed based care and community services is out of proportion and beds often get used to compensate for gaps in community based care. If we can reduce the number of beds, this would release the resources to make sure staffing levels in remaining community hospitals is sufficient, but importantly enable us to invest in the community service people want us to provide.

The cost of care provided at home is less expensive than similar care in community hospital beds, but quality is comparable. By this we mean we can treat more people safely and appropriately for the same amount of NHS money. This is a really important consideration as our population increases and greater demands are made on the NHS and we need to constantly strive to balance quality with cost.

The CCG is looking to identify the number of beds it wishes to commission for the future. In doing so any modelling of capacity required is based on a number of factors including

[1] http://www.newdevonccg.nhs.uk//your-ccg/northern-devon/northern-devon-board-meetings-and-papers/2014-board-papers-and-minutes/november-2014/101312

changing health needs and patterns of care. The result of the modelling is a greater understanding of the number of community hospital beds needed for the future. This then allows the CCG to work with providers who will be responsible for shifting the model of care to meet our strategic direction of care closer to home. It allows us to have confidence that we understand the complexity of the balance of the range of services needed in community settings. Whilst this is a CCG paper the modelling and recommendations have not been arrived at in isolation but by working with our colleagues in NDHT and social care to test our thinking and assumptions. A letter of support is provided in appendix 1.

This paper sets outs the proposal and the rationale for our view on the future number of community beds and then, the process for deciding where they should be located. Making an early decision on community hospital beds then allows us to understand how much money we have available to re-use to provide quality care in people's own homes and in the community.

This is a difficult and challenging decision to make and the document shares with people the factors which have influenced our thinking thus far, and our attempts to incorporate the views of as many people as practical to be transparent about the hard choices that we want to make to be able to offer more choice and control to greater numbers of people.

Whilst every attempt has been made to simplify the information, it can be complex. Members of the locality commissioning team have been keen to continue to explore the issues with colleagues, community representative and the public to ensure that there is a shared understanding of the contributing factors to the decision making process. The further stage determining the location will allow this sharing of the data and dilemmas to continue.

It is important to note the areas of concern the Northern Devon Locality Commissioning Board[2] of the CCG will have in making this recommendation. The decision regarding numbers of beds and locations is a separate decision from the operational roll out of the plan. However it is acknowledged that these are linked and it is hoped that this paper also provides reassurance that the implementation process is equally as important to those responsible for making commissioning decisions.

The Northern Devon Locality Commissioning Board members will need to have reassurance, and, offer the same reassurance to the public that the increased level of community services are in place to offset the closure of any beds. This is critically important and as part of the plans the CCG has agreed a 'gateway' process with Northern Devon Healthcare Trust. This process essentially describes the evidence that all parties need to have to enable the operational changes to take place. The provider has to manage the operational challenges that change initiates and at certain points there will be a requirement for a significant change and all parties will need to determine it is safe to move to the next phase.

Based on all the information we have collected our view is that there is a need to retain 40 beds in Northern Devon[3] for patients who meet the definition of using a community bed. We share the range of numbers suggested by different data sets and how we have determined this as being the best fit with the information we have. This document describes how we have arrived at this decision and then the number of options we have about their location.

[2] Often described as Locality Board for brevity

[3] The locality is covered by 22 practices from the border with Cornwall to the border with Somerset – a map of the community hospital bed locations covered by this proposal is on page 5- Holsworthy, Bideford, South Molton and Ilfracombe.

This document is divided into four sections:

- **Section 1 - Introduction**
- **Section 2 - How many beds?**
- **Section 3 – Where should the beds be?**
- **Section 4 - Next steps**

Section 1 Introduction

In the Northern, Eastern and Western CCG document, ***Transforming Community Services: Proposed Commissioning Intentions for the Northern Locality*** [4]we indicated the need to reduce our community hospital beds.

Community hospital beds have been used for many years to provide care for people in their own community; originally called cottage hospitals they were often funded by local donations, landowners or employers. The development of community hospitals was ad hoc, reflecting history rather than any national planning. The introduction of the NHS led to a divide, with some remaining private institutions whilst others moving into the NHS family. They were well loved by local people who often offered practical and financial support to patients and the facility and still do so today in many communities.

The increase in the size of hospitals and specialisation, combined with advancing technology and science has meant an increase in acute hospitals and a resultant need to change and diversify the role of community hospitals. There is a need to retain health services in the community and in many places community hospitals have lost their inpatient bed function but become dynamic and thriving hubs for healthcare in their communities. We are keen to develop services which bring care into the community wherever possible and safe to do so, reducing the impact on people where there is not a good reason to attend an acute hospital site.

Whilst necessary in larger numbers years ago, clinical expectations and expertise have changed and now there is a much smaller group of patients who really need the services that community hospital beds can provide. Much more care for more people can be provided in their own home, or the person needs to be cared for in an acute hospital setting with a much bigger infrastructure and clinical team. We do recognise though that for the foreseeable future, we must provide some beds for people who do not need to be in acute hospital care but cannot be cared for at home.

We therefore suggested in our document, a requirement to reduce the numbers of beds we have to match the on-going demand but at the same time release money that can then be re-used in the community providing care for people in their own home.

We are aware from the strength of feeling people have that community beds are precious, as they are tangible evidence of the NHS in towns across North Devon.

Community services are difficult to see, unless you are directly in receipt of care from them. People are not always aware of the amount and complexity of the care that can be provided and does occur every day in our community.

The Northern Locality Commissioning team (which includes clinical staff and managers) believe the right thing to do is to have the correct number of beds to meet the clinical need of patients , both now and for the future, but to reinvest the money saved by closing some beds into community services. Our first decision needs to be to describe **how many beds** we think we need and secondly where they need to be. The suggested bed number is described in this paper and we share the influencing factors for the CCG (acknowledging population predictions).

The second phase is then deciding where the beds should be. This is necessarily a little more subjective and various communities will have strong feelings about their own beds and the issues we should include in making the decision making process.

[4] http://www.newdevonccg.nhs.uk/get-involved/get-involved/community-services/northern-locality-commissioning-intentions/101250

The criteria have been suggested throughout our engagement process as we wish to continue to include community representatives in deciding which information we use and the relative importance of all the issues. This second part of the process will then allow us to decide where beds should be. We expect this process to elicit one answer. The plan for phase two of the process is also described in this paper.

This full answer will describe the total number of community hospital beds and the proposed location of these. This proposal will be recommended by the Locality Board of the Northern, Eastern and Western Devon Clinical Commissioning Group to its Governing Body for endorsement. If accepted the CCG will then enter into the formal consultation process required of it to demonstrate that it has met its obligations and has a strong evidence base to support the changed model.

Wherever the actual beds are finally located there will need to be a change in emphasis to meet the needs of the community. Beds will be 'community beds' and not 'town beds', this means that any person in the Northern Locality can be technically admitted to any bed and be cared for by the right clinical team including medical supervision. We will also need to ensure that access and discharge from beds can occur any time over the seven day period and for long periods of each day. There will need to be clarity around the clinical services that can be delivered and there will be an expectation that this suite of clinical services can always be delivered unless there is a catastrophic set of circumstances.

Bedded services must be used for active clinical reasons and not to overcome delays in securing community care services. If we don't make these changes the beds are in danger of not being used to full effect and will become an expensive drain on NHS services at a time when we have to be able to demonstrate the correct use of tax payers' funds.

Location of community beds in the northern locality- Bideford, South Molton, Ilfracombe, and Holsworthy

Why are we reviewing bed numbers?

The CCG has, through its' Transforming Community Services' [5] Programme explored the model of community services we require for the future to meet the needs of our changing population. The community services include complex care pathways, specialist community services, community urgent care services and prevention work streams. The bed modelling is an integral part of the complex care pathways for people who do not need acute hospital care but need support from health and social care to maintain their independence, to prevent illness where possible, and support them through illness and recovery where needed. This is a wide ranging definition and thus includes potentially all adults although the largest group of users will be older people and those with long term conditions. The supporting information we have collected suggests that wholly bed based care is not the right model for the future and this document helps to describe why we think this is the case.

We know that community beds are only part of the landscape of community services, but we see the change in their use and numbers as the key to releasing funds to redirect more care into home based settings. We do not have any funding put to one side to make this change so need to recycle money already in the system.

We have also been involved in a test of change in Torrington, where the increase in community services, led to an overall reduction in the use of community beds and, again where there has been a temporary closure of the Tyrrell Unit in Ilfracombe. The closure of the beds and increase in community services has led to an overall reduction in community bed usage.

Quality and safety

Attached as appendix 2 is the equality and quality impact assessment[6] we have undertaken in relation to the reduction in beds and increase in community services. The view of teams who have worked in areas where community services have increased and community bed numbers reduced is that it has helped the system to concentrate on getting people home safely and providing their care in the home. Previously when being transferred to community hospital beds as part of the routine process, there was a delay in rehabilitation with the lack of seven day services in community hospitals. Longer stays in hospital have a negative effect in terms of greater risk of hospital acquired infections, loss of confidence and potential increase in slips, trips and falls with unfamiliarity. Much of this is described in the EQIA.

The evaluation from Torrington shows an overall reduction in people going into long term care which would suggest that people are being helped to remain in their own home. It also shows (as does the Ilfracombe short term data sets) that our overall impact on the system is a reduction in overall length of stay in hospital for care as well as reductions in emergency admissions and attendances at emergency departments when compared with other communities. (The data for this is included in the EQIA).

The data also shows that the increase in community teams has led to an increase in numbers of visits as well as an overall extension in the face to face contact and direct care which is positive in supporting people.

The increase in community based care and reduction in bed based care does have a positive impact on a number of users of our services. The principles of quality and safety underpin all of our decisions and the Equality Impact Assessment identified that a number of patient groups positively benefit are those individuals who may need additional support for

[5] http://www.newdevonccg.nhs.uk/get-involved/get-involved/community-services/community-services-strategic-framework/101239

[6] Appendix 2 is separate from the main document and appendices

example, people with sensory or physical disabilities, those with dementia, learning disability or mental health needs.

We do recognise that quality and safety will be protected with the right model of community care. The paper describes issues of safety of staffing levels and the need to have a properly funded and trained workforce with underpinning support being in place in the community and from other providers such as domiciliary care. We acknowledge that we need further reassurance that providers can deliver the right skill mix and capacity of community based care and would hope that the gateway process described later would reassure readers that this is being taken very seriously.

Engaging and consulting with the public.

The engagement and consultation work we have undertaken has made us consider all of the community based services we provide as well as explore where more services could be provided in the community to reduce the impact on acute hospital care. The key documents related to this work are:

http://www.newdevonccg.nhs.uk/get-involved/get-involved/community-services/community-services-strategic-framework/101239

http://www.newdevonccg.nhs.uk/get-involved/get-involved/community-services/northern-locality-commissioning-intentions/101250

http://www.newdevonccg.nhs.uk/get-involved/get-involved/community-services/case-for-change-document/101240

These documents help to summarise the current thinking regarding community based services. Additionally the Northern Locality has also undertaken a test of change in community services in Torrington and all of the evidence collected for this is brought together in the board papers for November 2014. One of particular interest in terms of background information would be the evidence search from our public health colleagues in relation to the safety of community based (home based) services.

http://www.newdevonccg.nhs.uk//your-ccg/northern-devon/northern-devon-board-meetings-and-papers/2014-board-papers-and-minutes/november-2014/101312

We understand that as part of this process we need to work with the public throughout the commissioning process to share our thoughts and ideas, shape these and reach decisions which address the four tests for change for the NHS.

There has already been a process of engagement and consultation. For the Northern Locality this is described in out document

http://www.newdevonccg.nhs.uk/your-ccg/northern-devon/northern-devon-board-meetings-and-papers/2015-board-papers-and-minutes/february-2015/101483

This is an excerpt from the paper:

……..This section had the most responses and was subject to the greatest areas of concern for the public. The model of reducing the reliance on expensive hospital beds and having more community care available was understood and supported although the level of support for the changes reflected the opinions of local people and their use, knowledge and relationship with their community hospital.

Community hospitals are much loved institutions and are a visible sign of the NHS. Community services are often invisible and there is little knowledge shared about the number of people on a daily basis receiving health and social care in their own home.

There were also strong advocates of community based care, especially in enabling people to recover after illness in their own home with the right support and terminal and palliative care. Older people were also very keen to receive care in their own home when ill providing all the conditions were right to allow this to happen safely.

The concept of using hospital space to bring together more services so that the local community can receive health, social care and link with voluntary and community sector in one place was a well-received approach. We were able to describe examples of the type of care that is already available which prevented people travelling to the main hospital sites for care which could be received locally. We described these as health and social care hubs.

People liked these concepts as they were offered to the whole population, not just older people, so younger people and children could benefit as well as people of working age who would benefit from not taking so much time off work.

The decision about the numbers of beds and the location has not been made by the CCG but there was scepticism about this. People were very clear with us when we asked what criteria we should use to make the decision about locations and these will be factored into the planning. The message the CCG gave was that at this time and in the foreseeable future there is a need for some community hospital beds for healthcare needs but we would prefer to use the funds available to us to provide more community based care for more people than the current model.

- *People understand the proposal to reduce hospital community beds as they are an expensive way of providing care and the NHS pound can treat more people in their own home. People who live in communities without beds are more ambivalent about their retention. The strength of feeling and assumptions about hospital use in communities with beds was the bulk of our feedback.*
- *People were not aware of the cost of hospital beds and the higher costs associated with smaller units. The discussion about the safety of small units and lone working were broadly understood and people supported the need to consider this, although were concerned about what they saw as an inevitable closure of some units by default.*
- *People gave a number of reasons for keeping beds for uses which were not core business for the NHS as a way of keeping them, there were discussions about using them instead of care homes, more avoidance of hospital admissions, terminal care, and respite care and when social care was lacking. There was a need to be very clear about what the NHS should and could afford to pay for bed based care.*
- *The concept of care in people's own home was positively received but the CCG was challenged around a number of issues. Home care relies heavily on people for delivery, there are known problems in the northern locality generally and in some specific areas where capacity for domiciliary care in people's own homes is poor. This knowledge was also supported by stories about gaps in provision, unreliability, lack of continuity of care, poorly delivered care with untrained staff, a lack of compassion, poor equipment, poorly paid staff, lack of travel time and poor retention. We were challenged around our ability to improve this as a bed rock requirement for more care closer to home.*
- *Likewise the information people had received about gaps in clinical staff, especially nursing and doctors meant they were confused as to how we would contemplate a model of care which looked more labour intensive. We had to discuss the overall recruitment issues which are a national and local problem, but also describe the roles people played in community teams versus community hospital management and the greater job satisfaction community nursing provided.*
- *We had suggested that we could use care home beds in some locations to offer local care for some people who did not need an acute hospital bed, nor could be cared for*

at home. Similar to the domiciliary care debate we were asked about quality and capability of care homes and their staff and how we would work towards being reassured of this before using the beds on a regular basis.

- *You felt that community services should integrate better with primary care services so that all aspects of healthcare and social care with voluntary care are part of the same team.*
- *There was nervousness that a community service would be provided to allow closure of beds but would then reduce over time and the community would be left with very little.*

Our view is that the arguments for reducing the number of beds overall was understood, but there are clearly a number of issues which we need to provide much more reissuance about before the final closures can take place. This is an important reason for having a Gateway Review process for the bed closure and a number of key work plans to enhance various aspects of community services in the preparatory phases for closures.

We recognise that at this stage the public could rightly indicate that they have not been fully consulted on the decision because we have not shared the final bed closure options. This is accurate and the plans described in section three allow for a period of public based working to secure the preferred model of future bed configuration which will then be subject to further consultation before any changes are made.

Why do we need community hospital beds at all?

In undertaking this review of bed usage and future needs we have challenged ourselves to consider if we need community beds at all. We have been reviewing the information available in the National Audit of Intermediate Care which has just reported on the year 2014. This survey suggests there are many communities where there are few or no beds at all and all activity occurs in the patient's own home. Conversely there are some communities which have more beds than we currently do. Beds are part of the whole system of community services and in most instances numbers are a consequence of history and ability to develop community services to replace them.

We can see in the future that technology will change again and we do anticipate our bed usage will reduce again. We anticipate greater frequency of hospital beds being used just for rapid access diagnostics and treatment, a quick turnaround and people then having their care continued in the community. As bed based care is so costly and patient expectation drives a care closer to home agenda, we will see reducing lengths of stay and bed based care.

In the future we anticipate beds will be used for people who need some type of intervention which can only be undertaken on a site where they may be able to access complex equipment, services or a combination of clinical specialists. This need may be better served by the **acute hospital** where there is access to the complex equipment for diagnostics and treatment, operating theatres and a hub of a variety of clinical skills for people who have greater complex needs.

We anticipate seeing community hospitals changing their role to develop and offer day case care, simple diagnostics and outpatient facilities in partnership with other health and social care related services.

At this stage however our ability to predict a point at which no beds are necessary has too many variables. We also understand that the community services we have in the Northern locality are good as defined by the CQC, but we are still challenged by gaps in provision and need to provide equitable services across the patch so that everyone has access to them for all functions we require community services to deliver. We think an incremental approach to

this development is important so would not want to contemplate removing community beds entirely from the equation.

We have reviewed over several years the reasons why people use the community beds. Sometimes people are in community beds for good clinical reasons, that is that this is the right place and the only place for people to receive their care.

In other instances we find that people use beds for various reasons which are not really the best use of NHS resources, but use it because of gaps in other services, or delays in processes. Whilst we know we will never eradicate this, the NHS cannot continue to provide beds which are not for health reasons. This is described in more detail below.

Our review of the appropriate use of beds shows that people should largely fall into two health need categories:

Specialist Care. Some conditions require specialist skills as part of on-going rehabilitation and recovery e.g. patients who have suffered from a stroke. There are not enough patients needing this sort of service to suggest that every community hospital can provide this level of specialist service, but these skills need to be available and focussed on one community hospital site, but over time this may be felt to be an acute service and the benefits of locating this on an acute hospital site with greater intensity of care may lead to an overall reduction in length of stay and more rapid return to home and ongoing rehabilitation. (The bed numbers debate excludes beds for stroke care).

Complex, multi morbidity care. Some elderly people manage independently with a number of medical conditions, but this can be challenged when they become acutely unwell. Recovering and returning to independence can be difficult and if it is to be achieved might need bed based rehabilitation in the first instance. We also use beds to prevent an unnecessary admission to acute hospital care but this usage is limited it the right infrastructure is not in place to support rapid access to diagnostic tests and assessment.

We understand that the current use of community beds does not meet either of the two criteria above, instead we see the following:

- Community hospital beds are being used to deliver respite care, often in the absence of adequate community based care. As respite care will not require nursing or medical care it should not be delivered through a hospital admission.
- Community hospital beds are being used to deliver convalescence. As convalescence by definition does not require medical or nursing input it should not require a hospital admission. That is not to say that a person convalescing might not need care, but this nowadays should be delivered at home or possibly supported in a care home.
- Community beds are being used for needs which are social in nature although the reason for needing social care on a short term basis may be health related, for example if a person breaks a leg and is in a full leg plaster for a period of time and can't stand they may need help with personal care. A hospital beds is not needed for this if the person can have the social care at home or perhaps be cared for short term in a nearby care home.

We have completed audits of the needs of people using hospital beds over the last few years, this has been led by our Public Health Colleagues and is called an 'acuity audit' it essentially askes the question about the need of the person to be in a community bed. Consistently around 40% of people in a community hospital bed do not need to be there or should not be there.

We therefore anticipate in the future that community hospital beds will be used for people who do not need an acute hospital bed but cannot yet be safely cared for at home. We do not want to specify who can and cannot access a community hospital bed at this stage as we wish to evolve our community services so that care can be 'wrapped around' the patient in their own home. **We therefore anticipate our use of community hospital beds will be used for people whose clinical needs are too unpredictable to be able to rely on scheduled home visits**. To help to describe the need we see the following types of scenarios where a community bed is needed as the patient hits a financial or clinical tipping point as described below. These are not exhaustive and are suggested on the premise that the **first option for healthcare treatment would always be in the person's own bed.**

- A person needing palliative & terminal care
- A person having had a period of ill health and treatment in acute hospital but needs further clinical rehabilitation which cannot be provided at home.
- A person who has had an acute illness diagnosed but needs ongoing treatment (i.e. admitted to acute care for a range of tests etc. but then rapidly transferred to a bed for ongoing clinical care which cannot be provided at home.
- A direct admission into the community hospital for ongoing treatment and healthcare for an acute illness as part of a crisis care plan.

Modelling methodology allows us to consider honestly a clinical tipping point and a financial tipping point.

The clinical tipping point is the point at which the clinical need (or acuity) of a patient requires them to be in a hospital bed with 24/7 nursing care as a minimum as the ability of a community service to be able to provide for the intensity and continuity of care is debatable. There may also be a degree of unpredictability in need which contributes to this clinical tipping point as the risk of keeping the person at home is felt to be too great for the clinical team charged with responsibility for their care as they cannot safely anticipate their clinical needs.

The financial tipping point is different and refers to the cost of a package of care that would mean that it would be more cost effective for a patient to be cared for in an institution, rather than at home. It is recognised that cost effectiveness is from the NHS and social care perspective and we acknowledge that the impact on the family is not considered as each case will be different, but the overall impact on carers has been picked up in equality impact assessments. NDHT undertook this extensive analysis on our behalf and with our support.

SECTION 2: How many beds?

Readers will recall we had worked with Northern Devon Healthcare Trust (NDHT) to try to predict our future needs using modelling techniques. The Northern Locality currently has 74 beds in use although the Ilfracombe beds are temporarily closed. It can be seen that there are more bed spaces available in the community which could be used, although none of these spaces are vacant but are used for other services and would probably need some investment in most to get them up to operating standard as well as incur some type of relocation cost. The table below describes the current and possible bed numbers but we will factor in the flexibility benefits as part of the second stage of the decision making process. We have assumed similar numbers where it would be easy to make changes.

	beds in use	bed spaces which could be used
Holsworthy	20	28
South Molton	20	28
Ilfracombe	10	16/20*
Bideford	24	28
	74	

**The Tyrell unit cannot accommodate 16/20 beds in current format but is still included at this stage in the debate. See page 16 for further details.*

Modelling bed numbers

We have worked with NDHT and Public Health to develop a modelling approach to trying to determine the total number of beds we need for the future. We have factored in as much detail as we can, but do need to acknowledge we have also had to make some judgements where there is conflicting information. We have been cautious thus far, but need to factor in other issues which then influence our options and discount some options quite rapidly.

The modelling methodology we have chosen uses complex data from a number of different sources, including Public Health data, Acuity Audits, Community Services Activity by volume, complexity and acuity, Patient Cohort (step up and step down) Acute hospital data, Social Care data, Emergency care data and Primary care case studies. Other examples of service change around the country have also been used as benchmarks.

Some specialist services have previously been focussed on single sites because of the relatively small number of patients and the necessity to maintain the clinical competencies of staff. Specialist skills need to be preserved in any new model of care

The range of beds required after modelling suggests the need for **45-64**, which is less than the beds currently based outside acute hospitals care (currently 74). These figures are based on an 85% bed occupancy which is a figure used by the NHS to allow for 'throughput' this means we allow enough time for people to be discharged and readmitted without delay and thus includes a number of vacant beds at any one time.

This 85% bed occupancy is the guide for emergency use of beds. It can be considered that whilst there may be some avoidance of hospital admission services using community beds, in reality the numbers will be small and thus the overall bed assessment is reduced by 15% again so that we are now contemplating a range of **39 and 55 beds if all beds were fully occupied (100%).** This is used for comparison, but it is recognised that 100% bed occupancy is unlikely but larger units usually have better bed utilisation so the figure is probably somewhere between the two.

Another crude way of looking at the numbers needed would be to contemplate our current bed stock of 84 beds (which includes the now closed beds in Torrington) the acuity audits completed before this last closure suggested 40% of the beds were consistently used by people who should not have been in them. Therefore another way of determining the

number would be a straight number reduction population, this would suggest that only **50 beds** are needed.

The National Audit of Intermediate Care [7] provides a summary of the numbers of commissioned community hospital beds per 100,000 populations. The average number was 23.7 beds per 100,000. If this figure was used for the northern locality based on 159,000 is **38 beds.**

Bed occupancy for community hospitals have always been a conundrum as, even in times of high pressure in North Devon District Hospital (winter pressures, infection control outbreaks etc.) there is bed availability in community hospitals. A table **(appendix 3)** is attached which demonstrates this, showing all of the days between September and December 2014 when North Devon Hospital was on red alert and the bed availability in community hospitals.

Additionally we also have our local data which describes the actual need for beds as additional service have been put in place. We have two tests of change, the work in Torrington where we have a permanent closure of beds, the second being in Ilfracombe where the temporary closure of beds gives us further information. These are both showing that with increased community nursing teams more staff are being cared for at home and less community hospital beds are needed. There is, in both of these last scenarios less people are being admitted to acute hospital care as well, although the overall length of stay has increased slightly, but this would seem reasonable based on clinical need.

People have also asked us to predict based on future population needs so we have included a summary based on predicted population for 2021 Office of National Statistics:

Model	**population 2013 ONS estimate**	**no of beds now**	**population projected to 2021 (ONS data and projections)**	**no of beds**
NDHT modelling using a combination of all data	159,000	45-64 beds	169,000	45-64 beds
NDHT model which only allows for 85% bed occupancy shifted to 100% bed occupancy		39-55 beds		39-55 beds
Acuity audit assuming that 40% of beds were used for options we would not contemplate in the future		50 beds		50 beds
National audit of intermediate care which suggests o 23.7 beds per 100,000 population		38 beds		40 bed
Torrington data based on 2.5 beds per 13k population – actual		31 beds		33 beds
Ilfracombe data based on 2.5 per 12,000 population (five months data actual).		33 beds		35 beds

Based on this review activity and clinical data the view would be that 40 beds would be the right number to work with, but variation in the models to suggest resilience and flexibility should be important criteria in the selection of location. We need to be cautious that every extra bed reduces our ability to shift resources into community based services.

Other factors influencing our decision making

We then have a number of operational safety, clinical and financial issues which are really important to factor into our decision making process.

[7] http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care.php

Staffing ratios and registered nurse establishments.

For the purposes of this option appraisal we are assuming we will move towards safer staffing levels in terms of avoiding registered nurses working alone in community hospitals. This is not safe for the nurse or patients and leads to a greater potential risk than is necessary. A range of factors come into play in determining safe staffing levels, acuity of patients and their needs, skill mix, clinical isolation and layout are all contributing factors.

Staff working in community hospitals are required not only to manage the care of their patients but also any planned or unexpected visitors to the building. Having just one registered nurse on duty at any one time makes this range of responsibilities unrealistic for the registered nurse. Whilst there will be trained health care assistants providing support the whole responsibilities lies with the trained nurse. The other consideration is the lack of peer support and challenge in managing care safely which is part and parcel of good clinical care. Opportunities for training and clinical audit are limited.

The Mid Staffordshire enquiry and other key reviews of the NHS considers there are direct correlations between nursing and clinical establishment of staff and the quality of care & safety received by patients and their families. NDHT suggests that it wants to move to a staffing ratio of one nurse to eight patients at any time in community hospitals.

The CCG would support NDHT to move to larger units as a way of consolidation to remain clinically and financially sustainable, increasing the registered nurse establishments and reducing lone working. The CCG does not expect a blanket approach to staffing ratios for community hospitals but staffing to meet the clinical needs of the patient population. The providers are accountable for setting and ensuring safer staffing levels for delivering high quality, safe care. The CCG would expect the provider to ensure that the community beds were only used in instances where the health needs of the patient made their use necessary as described previously in this paper. The CCG would also expect that any restrictions to access to the community beds which may compromise the whole model of community services are removed e.g. admission and discharge restrictions, access permissions, suitability of clinical cover etc. This enables the resource to be used for the whole community. The larger the units the more cost effective they become in term of staffing costs. Figures provided by the CCG and NDHT demonstrate the difference in cost for nursing staff per bed depending upon the size of the unit.

Type of facility	Cost per bed per annum
Care home bed (including support infrastructure)	£39k
One bed in an 8 bedded community hospital	£75k
One bed in a 16 bedded community hospital unit	£56k
One bed in a 24 bedded community hospital unit	£46k

(These are provided by NDHT and are based on a 1:8 nursing ratio)

Nursing home beds

There are a limited number of care homes in the northern locality which provide nursing care. This means they have registered nurses on duty at all times as the patients have health needs which need to be overseen by a registered health professional. Care home beds have routinely been used for long term care, either funded privately, by the NHS, social care or a combination. Care homes in many places in the county have extended their roles and often now take patients for shorter placements. With good quality support and training opportunities, care homes can be in the position to provide short term placements in a

number of situations, for example terminal and palliative care, avoidance of admissions to hospital, respite where nursing care is needed and supporting rehabilitation, again where health care input is needed.

Work with the Partnerships Directorate considering capability and capacity of care homes and the other competing demands for spaces have led us to suggest that at this stage it would be reasonable to factor in spot purchasing no more than eight beds on a regular basis. This has been verified by an audit over several weeks running up to and Christmas where the bed & staffing availability of nursing homes have been checked. It became clear that even when beds were available the staffing would not always be in place to meet the needs of additional patients. We would wish to acknowledge there are some excellent homes providing good quality care despite the bad publicity the sector often receives, but there is more support we need to provide to boost the proportion of good care homes. Work is underway across the county to understand how we support the market to provide high quality care in the capacity needed so we are being cautious in our plans to over burden the market at this stage in our assumptions.

This would then allow us to 'flex up' if needed but be more reassured that beds are available where and when needed. Therefore any options for the use of care homes which suggest spot purchasing more than 8 beds are not going to be considered. In time, if beds were regularly used in a location because it met need and a trend developed the CCG could consider block purchasing some beds which would provide some reassurance about availability and offer some stability to care homes which is sometimes a very vulnerable market as they often rely heavily on statutory funding.

Financial position

It is well known that the NHS in Devon has severe financial difficulties and is one of the most financially challenged communities in the country. If nothing is done to reverse this trend the community will have an overspend of £430 million by 2020. This is clearly unsustainable and work is underway to redress this but it will be a mammoth task for the community to reduce costs and get back into financial balance. We could ignore this and insist that community funds should be protected at all costs. However, pretending this financial difficulty doesn't exist means that we will be constantly at risk of short term and sudden financial savings programmes which would destabilise our infrastructure and may well be in areas which would not be our choice or preference.

Currently community services in the north overspend their community budget allocation of £700k, so any option which does not recover this overspend as a full year effect as a minimum should be discounted. Continuing the overspend means that other people are not receiving care who should be so it is unfair to continue to run with this level of known overspend. Additionally as the figure included for community team increases is an estimate and the opportunity for save more in beds to reinvest in community should be considered.

We have this year increased our budget for community services but this is still on the assumption that the £700k be saved. We would also plan that any additional funding added into the community system would not be to increase the bed based care but concentrate on community services (remembering that this may not all be allocated to our community service provider, but may be needed to increase resources in primary care, social care and community and voluntary services). We are therefore stating that the future model of bed based care needs to enable two actions:

- Release the £700k non-recurrently so that the community budgets are back in financial balance.
- Release sufficient money to have increased community teams as described below in section 5.6.

We have been asked why we are just looking at the community services portion of the budget and thus to beds for the saving. Our long term aim as a CCG is to release funding from acute services and reinvest in the community. We have made the commitment that the proportion of money spent by the CCG on community services must not reduce, but must remember that we are a financially challenged health community and thus before any money is released to be reinvested to spend on further community services we must pay off larger overspends on acute hospital services first. We are considering all services provided by acute hospitals, for their efficiency, capacity, and operational effectiveness in the same way as community services.

We are working from the evidence we have collected especially with our test of change in Torrington which shows that more services can be provided for more people, for the same amount of money. We are therefore convinced that our community services budget which is £22,843,000 for the 159,000 population could be spent in a way that offers more services for people. This equates crudely to a head count figure of £144 per head of population which is very close to the CCG wider average of £143 per head of population spent on community services. We can therefore be confident that the funds allocated by the CCG for community services in the Northern Locality could be deemed a fair share of the total, which is a question, asked many times of us by the public.

If we could redirect some of the funds spent in community hospital beds to community based home services this would allow us to do far more. We could help plan more effectively for acute illness for people with a long term conditions, undertake more disease prevention, or where there is ill health a further deterioration, support social care more effectively and our frail elderly people in care homes. It would also allow for faster reactive care in the community to reduce emergency attendances at hospital.

All of this allows us to be more proactive in reducing the spend in acute hospitals and thus help us get back into financial balance and redirect resources to preventative and planned healthcare.

Movement of the stroke beds

We know that larger units are safer and more cost effective and one of the options in each scenario grouping suggests the relocation of the stroke beds from Bideford to North Devon District Hospital. This would then allow a co-location of more community services on one site thereby increasing resilience, sustainability and access. This option remains in as NDHT has confirmed that co-locating the acute and community elements of the stroke service under one roof is supported by its stroke clinicians, albeit an option which is subject to public consultation by the Trust. This leaves spare capacity in Bideford Hospital which could be used for other developments that support independence.

Movement of community hospital beds onto the acute hospital site at North Devon District Hospital ain Barnstaple.

In the same way as stroke beds we are exploring if it would make sense to have some of the beds placed back on the main hospital site. This would allow a great number of beds to be collocated which does reduce costs per bed for nursing care. NDHT are considering this, but at the same time are planning to relocate the stroke beds which take up a lot of actual space and may not be able to contemplate this in the short term. This has thus been highlighted as a future possibility but not factored into the permutations at this stage but could be reconsidered at a later date.

Increasing community teams

We now have real experience of the impact of closing community beds and increasing community teams. In the Torrington model the cost per bed displaced was estimated at

circa £20 k (whilst more investment than this occurred it was acknowledged that the Torrington community staffing establishments were some of the poorest in the locality). Ilfracombe has been temporarily closed due to safer staffing and whilst we still aren't sure that the amount added into the community team is correct we did nominally add a further £13.5k of additional staffing per community bed lost. In this model we have therefore allowed for £25k per community bed lost, as a reasonable estimate.

We are aware that we haven't agreed the right level of community staffing for the teams across the locality we need for the future and we also need to make sure that when we describe the team we consider resource for the wider team including social care, primary care, equipment, consultant expertise and medicines optimisation support.

As well as not yet agreeing the size of the teams we also need to start to explore productivity and output metrics, i.e. what do we get from each of our teams, how busy are they and how do they contribute to saving emergency admissions, end of life care, maintaining people safely at home and managing and anticipating crises and discharge planning.

We do know that our community services have been reviewed by the CQC and in terms of safety and quality they are very good. Our challenge will be in working together to embrace new technology, pushing the boundaries of community based care, and agreeing a shared approach for community and primary care for a more integrated approach.

Primary care is a challenging place to work and primary care teams are feeling the pressure of the increase in community based care coupled with public expectation and demand. We believe that by working in a more integrated way with the community services team (who are already integrated with social care) there could be a way of sharing workload, reducing duplication and providing mutual support which then creates a better network for patients. We need to explore the role of pharmacists, and continue the discussions which have already commenced about the role of hospital consultants in community settings and their specialist role in supporting the community services. We need to acknowledge that our clinical workforce is our greatest resource and enable them to work in the most pragmatic and co-ordinated way possible.

Adjacent beds

Especially for the western end of the northern locality, discussions have been had with Kernow CCG to understand what the potential opportunities are for using the bed based services in Stratton and Launceston. Additional beds have been funded at Stratton in the recent past but these are not fully operational due to building rectifications. The beds do also appear to be second order priority in that if there is a staffing issue the cover of the beds in Launceston is first priority. The CCG with the provider of community beds is also looking to review bed based care so there does not seem to be a clear future use of the beds and therefore this has been discounted from the planning at this stage. (At the time of writing this paper there is a further reduction of beds in Stratton with the temporary closure leaving only six inpatient beds).

Ilfracombe

Based on our support for the move towards safer staffing levels balanced with finances the current size of the Ilfracombe unit would mean it would be discounted as it only has ten beds and no facility currently to extend its bed establishment to 16/20 beds which would appear to be the minimum size of a bed based unit for the future.

We have however left Ilfracombe in as a location at the moment but are undertaking work to explore if there is any opportunity to increase the size of a bed based unit. The NHS would not be able to secure any capital to undertake an extension or a new build of this nature, but would support a local community bid, if it was identified as the best location for beds for the

northern locality. By the time the second phase is reached this possibility will need to be included or discounted. The options therefore include a 20 bed unit for Ilfracombe at this stage. We acknowledge that continuing to include this option may create some confusion but feel that we are obliged to continue to include it for the time until it can be discounted or guaranteed, even though work in Ilfracombe is now concentrating more on the possibilities of increasing community service provision.

Other models with different numbers of beds.

It will be possible for people to search and identify community units with smaller numbers of beds than the 16/20 beds suggested as being optimum for clinical safety and operational efficiency. In exploring these more, it is important to note that there may be other factors which influence the decisions in other communities for example, other 24 hour services being on site which can provide mutual support, lack of availability of care homes, smaller caseloads for home based services which make the financial and clinical tipping points different in those communities.

The options

We have included appendix 4 which describes in some detail our financial modelling of the various options we are contemplating. The challenge for us is balancing the ongoing need for some community beds, with sufficient home based community services in a way that is financially sustainable and commits us to a good quality service where NHS resources are used correctly to meet patient need.

The tables describe a range of bed numbers and configurations; please note that where an option suggests a twenty bedded unit, it could be one of four units, so that for some options there are actually more than four permutations. It is possible to see quite quickly that some of the options are unaffordable if we are to meet our multiple aims of securing a smaller number of safely staffed beds, removing our overspend, and enabling enough money to be released to be reinvested in the community.

Conclusion

Based on the estimates of bed numbers needed for our population information, the conclusion already described is that the Northern Locality need to retain forty beds in the community to ensure there are sufficient beds to meet local need at this point in time (and projected forward).

The additional information in relation to affordability would suggest that we can afford to continue to provide either forty four or forty beds for the community in a number of scenarios.

This would allow sufficient funds to be released to create more resilient community based (home) services and allow us to progress our wish to move more health and social care services into community hubs.

The beds can provide in many different permutations. (An option forty four beds is left in as costs are comparable to forty beds). The wide range of options is tabled in the appendix.

Recommendation

The next stage of the decision making process is based on forty beds being needed for the future for patient care as part of the landscape of community services and the same numbers also being affordable.

SECTION 2: Where should the beds be?

Now we have got to a shorter list of options we then need to move towards a single preferred option. As described earlier this is the phase that is likely to be contentious and there will be a wide range of passionate views about the choices we have. The previous section has brought us to the point of expecting that two community hospitals will continue in the Northern locality but which two now needs further debate.

During our engagement process we asked people their views on the important criteria which should influence our final decision. There was a consistency in responses around rurality, access, transport etc. As expected each community had strongly held views and whilst there appears to be an acceptance of the rationale for reducing the beds generally and reinvesting the money in community services, each community can make an excellent case for their beds being the ones that remain. The key issues highlighted by the public are all included for further discussion. Some may be discounted on further discussion as the criteria may not impact on the location of beds as initially thought. Some criteria may have an absolute link between health and wellbeing but the connection with bed based care is unclear or felt not to be necessarily relevant.

Our suggested approach.

We believe we should agree with the representatives of the community and the providers the important criteria to be considered to help us make a final decision and ask our main provider of care, NDHT to lead this next stage of the process with our support as they are accountable for operationally delivering safe and sufficient care. This needs further exploration. An initial list is offered but we would be interested in finding out if there are any additional criteria that the community would like to include or if there are any which people feel should not be included (these have been collated from the engagement exercise and are not necessarily the views of the CCG).

The options suggested have been summarised in table form below but appendix 5 offers some more detail describing the criteria, why it was suggested it be included and the information that could be used to quantify the impact. These criteria need to be challenged to ensure there is an avoidance of double counting or duplication of criteria.

The suggested approach would be to invite members of councils, Healthwatch, League of Friends and voluntary and community sector groups and NDHT to join with us to review the criteria. The key actions would need to be:

- Agree the list of criteria – and confirm why they are important.
- Agree how the criteria would be measured, that is what information will be acceptable as a good indicator of the criteria, some examples are included in the appendix.
- Agree the weighting of the criteria – i.e. decide which of the criteria are more important than others and thus should influence the outcome more.

The CCG would then be able to take this information and apply the wishes of the community to each combination of two hospitals and come to a preferred option.

Suggested criteria

The list below is based on information provided by people as part of the engagement process with some additional factors the CCG would anticipate would be included. This is the long list and will need to be subject to the process described above.

What factors are important when making decisions about the future of community hospitals?

SECTION 3: Next steps

After the decision on the number of beds in May and then the work with the selection of locations over the summer, by September it is expected that the community will be able to make a recommendation on the future model of community beds. This process will have led to a preferred option which will be presented to the locality board as the future model of community bed provision for the northern locality. Once approved there will need to be a period of further consultation to allow any further issues to rise to the surface.

The Locality Board members are conscious that whilst they have been elected by member practices to represent their views, they do not necessarily reflect each community and would be concerned if there was any implication of a lack of fairness in the process. To overcome this a sub group of the locality board will be set up as a time limited process to oversee the development of the criteria and weighting in order to assure the board that there has been a transparent and consistent approach. Terms of reference for this sub group are attached at appendix 5.

It is hoped that this very open and transparent approach to the decision making process and further opportunities to involve the public will avoid the potential of legal challenge, but also enable the public to enter into the positive planning for the future. Our experience with the Torrington test of change has been that the energy of some of the community representatives has been consumed by the fight to keep beds to the detriment of the opportunity of influencing the development of the community teams and other health services which could improve care in community settings. We would be keen to avoid this.

It is acknowledged that the outcome will not be agreeable to everyone. The best that can be hoped for is that the public believe that decisions have been made with the best interest of the community at the heart and the CCG proposal is supported as the best solution for using the NHS resources available.

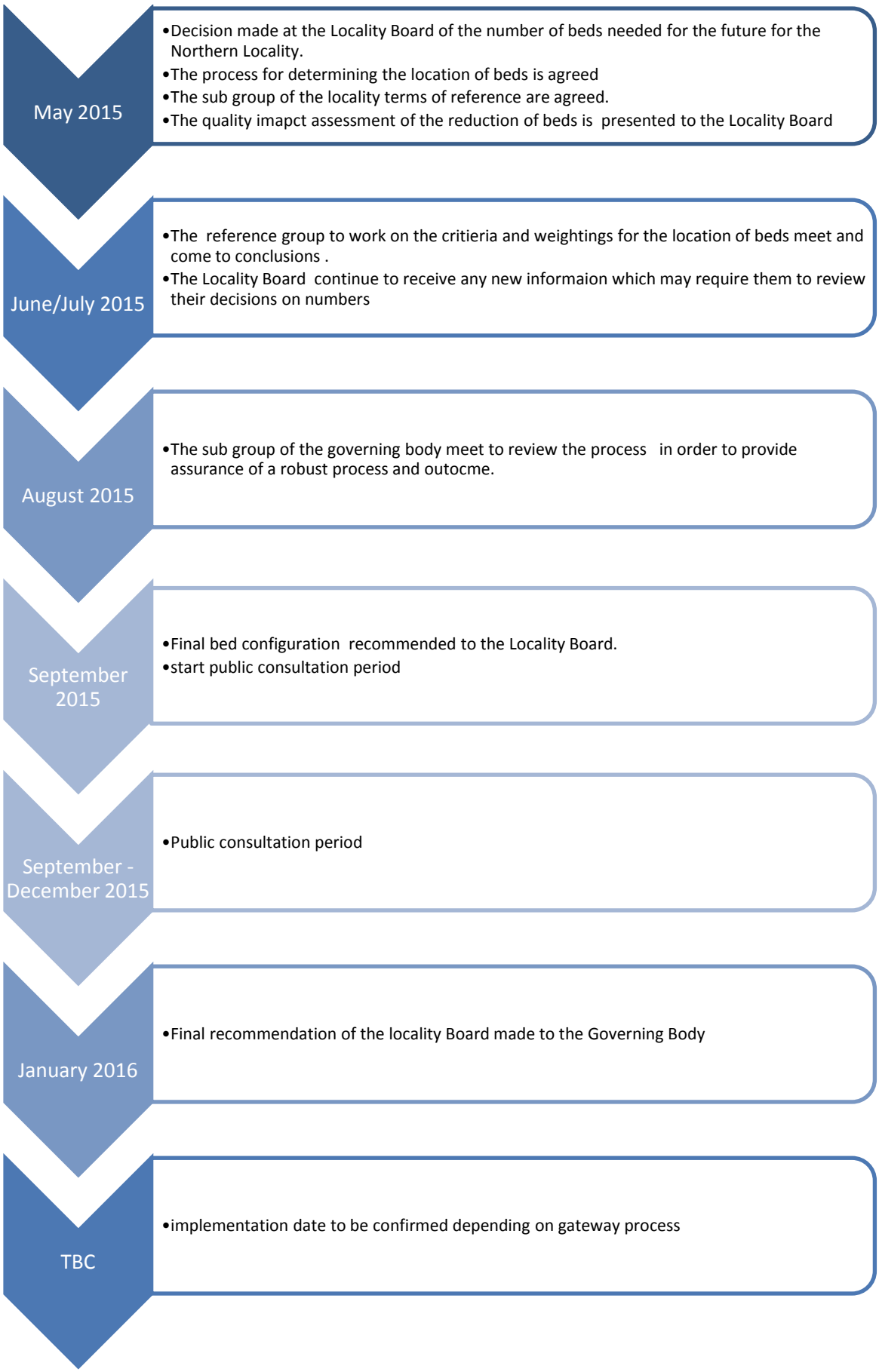
Whilst this is intended to be a ‘future proofed’ proposal it is important to reflect that we cannot predict the future and it will be important to put a process in place that offers some reflection at each point a key change is planned.

It is presumed that there will need to be a roll out plan which will be influenced by the speed at which the community teams can be increased and community hospital beds reduced which will need to be shared and agreed plan between the provider and commissioner.

This will be challenging as we know that as soon as a closure is announced, there is an impact on staffing and recruitment and thus will need to be balanced against the development of the enhanced community models of care and agree points at which the operational model will shift.

A summary of the decision making timetable for the CCG

A summary of the decision making process is provided below to share with people who will be involved and at what point in the year. Some of the dates are subject to external factors but this is our expected timetable:


May 2015
•Decision made at the Locality Board of the number of beds needed for the future for the Northern Locality.
•The process for determining the location of beds is agreed
•The sub group of the locality terms of reference are agreed.
•The quality imapct assessment of the reduction of beds is presented to the Locality Board
June/July 2015
•The reference group to work on the critieria and weightings for the location of beds meet and come to conclusions .
•The Locality Board continue to receive any new informaion which may require them to review their decisions on numbers
August 2015
•The sub group of the governing body meet to review the process in order to provide assurance of a robust process and outocme.
September 2015
•Final bed configuration recommended to the Locality Board.
•start public consultation period
September - December 2015
•Public consultation period
January 2016
•Final recommendation of the locality Board made to the Governing Body
TBC
•implementation date to be confirmed depending on gateway process

Implementing the decision

The success of the new model will be dictated by the ability of the community based services to respond to meet the needs of residents safely and in a timely way to a high quality of care. We have been challenged on the robustness of all community services, be they primary care, community health and social care, voluntary sector, carers and the private sector. Providing complete and guaranteed reassurance is not possible but we can work together to ensure that the infrastructure we have is sufficiently robust to make the changes. Indeed, previous experience would suggest that sometime the changes and resilience can't be fully tested until such time as the change occurs.

In order to provide the fullest levels of reassurance possible the CCG wishes to work with partners using a comprehensive improvement and implementation plan and gateway process. Gateway processes are used regularly now in project management and describes various points in the process where checks are named that all is going to plan and there are no unintended consequences, before the next step is taken. The key purpose of this is to ensure the following:

- People with appropriate skills and experience are deployed on the project and to manage the project.
- All the stakeholders covered by the project fully understand the project status and the issues involved
- The project is ready to progress to the next stage of development or implementation
- There is visibility of realistic time and cost targets for projects
- It provides an opportunity for the provider and commissioner to work together in a volatile environment with competing financial and operational scenarios. We have to acknowledge this will create tensions in timescales for delivery and there is potential for different views on operational readiness.

A copy of the draft gateway process checklist is attached at appendix 7.

Conclusion

The model of community based care described in our care closer to home submission has been supported by the engagement process although there is understandable nervousness with regards to the actual process of change, with regards to the loss of community beds and the implementation of the enhanced model of community care.

Our assessment of the local experiences and national evidence is that the reduction in bed based care and rebalancing with more community support has a positive impact for people and provides good quality care The right balance of the various services in an integrated community model which is sufficient to meet the health needs of the community is important for two reasons, not only to release funding to provide more community based services, but secondly and more importantly ensure that the right quality and type of care is available for people when they need it.

This paper recommends that forty community hospital beds used for the right clinical reasons enables us to reinvest more money into community based services to meet more needs for our population in the way that they have expressed they would want to be cared for in the future; that is wherever possible and safe to do so at home.

We would want to support our commissioned providers of care to use the NHS resource in the most cost effective way to meet the increasing needs of the population we serve in a person centred way.

Final recommendation to the board.

Board members are asked to consider the content and supporting information and agree the following:

- That we signal to our providers that we believe that forty community beds should be sufficient to meet the needs of the community we serve if used as described.
- We will notify the Governing Body of the CCG and the Transforming Community Services Executive of this decision.
- We work with our providers to develop an implementation plan to roll out a reduction in overall bed numbers and increase in integrated community based services. This implementation plan must address the issues which have been raised as areas of concern and use the gateway process described to reassure ourselves and the public that all aspects of the model are being addressed.
- We ask our provider to take the lead in determining as part of the plan the location for the longer term of the reduced number of beds, acknowledging their responsibility for delivering safe care, in line with the process we are proposing.
- We ensure that responsibilities for continued engagement and formal consultation are met.
- We accept that we will need to continue to review our plans in the light of any new information which may be forthcoming.
- We receive regular updates on process and consider all contractual levers and incentives to implement the model of care described and supported in our care closer to home strategy.

Elaine Fitzsimmons

Associate NEW Devon CCG

Northern Devon Healthcare NHS
NHS Trust

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Our Ref: AD/KA/KW

20th May 2015

Mrs E. Fitzsimmons,
Associate,
NEW Devon CCG,
Windsor House,
Tavistock Road,
Plymouth.
PL6 5UF

Dear Elaine,

Thank you for sharing the bed modelling paper with the Trust. We greatly appreciate the opportunity to comment on the exciting direction of travel contained therein.

We were pleased to see the case being made for moving towards a model of care where people are supported – where possible in their own home – to remain independent as well as prioritising sustainable acute services at NDDH. As a provider, we share your vision of ensuring we support the move towards prevention of illness and dependence and the move towards a 'wellness' service.

Given the national picture of nursing and doctor skills shortages we also feel that the only way to preserve clinically sustainable community services in Northern Devon is to consolidate. This will allow us to concentrate expertise in fewer sites in order to provide better, more consistent and resilient services to patients.

In terms of our formal response to the consultation we look forward to further discussions with the CCG. However it is likely our response will support any model which reflects our professional views on safer staffing and the skill mix of staff needed for the acuity of patients as well as what is sustainable for northern Devon.

There are some difficult choices ahead and as the provider of both acute services at NDDH as well as community hospitals and health and social care we feel Northern Devon needs to prioritise those health services that deliver the greatest benefit for patients rather than the way things have been historically done in the past.

Kind regards.

Yours sincerely,

Alison Diamond
Chief Executive

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APPENDIX 1

	Bideford (Willow & Elizabeth)			Holsworthy			Ilfracombe			South Molton			Total		
Date/Ward	Available	Occupied		Available	Occupied		Available	Occupied		Available	Occupied		Available	Occupied	
01/09/2014	36	31	86%	10	10	100%	10	10	100%	20	20	100%	76	71	93%
02/09/2014	36	31	86%	10	10	100%	10	10	100%	20	20	100%	76	71	93%
18/09/2014	36	30	83%	13	11	85%	10	10	100%	20	19	95%	79	70	89%
19/09/2014	36	28	78%	13	11	85%	10	10	100%	20	18	90%	79	67	85%
21/10/2014	36	35	97%	16	16	100%	10	4	40%	20	18	90%	82	73	89%
29/10/2014	36	32	89%	16	16	100%	Beds not open			20	20	100%	72	68	94%
11/11/2014	36	30	83%	16	16	100%	Beds not open			20	17	85%	72	63	88%
12/11/2014	36	30	83%	16	16	100%	Beds not open			20	16	80%	72	62	86%
25/11/2014	36	30	83%	16	13	81%	Beds not open			20	19	95%	72	62	86%
26/11/2014	36	32	89%	16	15	94%	Beds not open			20	20	100%	72	67	93%
27/11/2014	36	31	86%	16	16	100%	Beds not open			20	20	100%	72	67	93%
28/11/2014	36	33	92%	16	16	100%	Beds not open			20	20	100%	72	69	96%
16/12/2014	36	30	83%	16	15	94%	Beds not open			20	14	70%	72	59	82%
17/12/2014	36	28	78%	16	15	94%	Beds not open			20	14	70%	72	57	79%
18/12/2014	36	28	78%	16	16	100%	Beds not open			20	15	75%	72	59	82%
19/12/2014	36	28	78%	16	16	100%	Beds not open			20	15	75%	72	59	82%
21/12/2014	36	28	78%	16	15	94%	Beds not open			20	14	70%	72	57	79%
22/12/2014	28	25	89%	16	13	81%	Beds not open			20	14	70%	64	52	81%
23/12/2014	28	23	82%	16	13	81%	Beds not open			20	16	80%	64	52	81%
29/12/2014	32	26	81%	16	16	100%	Beds not open			20	14	70%	68	56	82%
30/12/2014	32	27	84%	16	16	100%	Beds not open			20	14	70%	68	57	84%
31/12/2014	32	31	97%	16	15	94%	Beds not open			20	14	70%	68	60	88%

This table matches days when the acute hospital was on red alert with the bed availability in the community hospitals in the period between 1st September 2014 and 31st December 2014.

APPENDIX 3

APPENDIX 4

Financial modelling

Our view before considering the financial implications is that the number of beds we should be contemplating is 40 with some degree of flexibility.

The costing scenarios

For the first stage of the option appraisal we have to determine the right number of beds for the northern locality in order to determine the right clinical mix of beds and community services we have needed to make a number of financial assumptions. The costing scenarios we have used are based on the following:

- The costs are for nursing teams only as it is expected that all other clinical staff will be redirected to the community services and that infrastructure staff will need to be retained unless a whole hospital is closed. We have used the 1:8 nursing staffing ratios as a rule, as our expectation is that as we use the community beds in line with the criteria we described earlier, patients may need more intensive clinical care than the current model and use of community beds requires. We have therefore allowed for a higher nursing establishment which could then be used flexibly. However the staffing cost per unit must be agreed as all money spent on inpatient beds distracts from investment in the community. The costs we have used are detailed below. Smaller units cost more because the minimum staffing levels needed mean that staff needs to be employed event though they are not fully utilised, but have to be there in case of need. Therefore larger units increase the overall staffing but also improve the efficiency of the staff time. 16/20 bedded units therefore are described with the same costs.

    - 16 bedded units – £900,000
    - 20 bedded units – £900,000
    - 24 bedded unit £1,100,000
    - 28 bedded unit £1,300,000

- Care home beds are calculated at £750 per bed per week or £39,000 per annum for a fully occupied bed for a year, the cost per bed does not necessarily mean that all of this funding will be paid to care homes, and there are standard rates paid and then often negotiation to meet specific clinical needs. If these are used the clinical teams will need to provide support to care homes in the same way they would to patients in their own homes, but additionally the community team including primary care may also need to offer intervention over and above and we need to be sure that this is acknowledged and allowed for in our planning.

We have developed a matrix which is based on a range of different bed numbers. Whilst our impression was that the lower end of the suggested scale would be more likely we have included higher numbers of beds to demonstrate the impact.

We are, for completeness setting out costing tables a range of bed numbers. Please note that the following configurations are being used but there could be slight variations on these. We know what the maximum bed spaces available in each community hospital may be but when considering the impact of staffing various configurations because of internal design and changed space requirements we have been cautious in our planning. We are very supportive of the safer staffing issues as described earlier and the larger unit sizes supports the ability to avoid lone working. In some instances the staffing cost may be the same for more than once option of beds in a setting and this is caused by the impact of stepped costing, especially in relation to qualified nursing time where acuity may dictate a number even if the staffing time is not fully utilised. This is one of the risks of bed based care in smaller units where staff cannot be shared effectively.

Community Hospital	**number of beds**	**number of beds- future models**
Holsworthy	20	20 – 28 beds
South Molton	20	20 – 28 beds
Ilfracombe	10	16/20
Bideford	24	up to 28 beds
	74	

Option 1 – do nothing

We are not going to work on a do nothing option on the basis that we know that the current do nothing option does not meet out need to identify £700 k saving, it doesn't allow us to release any resource to improve community services, nor does it address the safer staffing models for clinical teams.

Option 1: Sixty four beds.

We have considered the following permutations of community hospital beds plus nursing home beds where needed:

- **2 @ 20 beds plus 1 @24 beds**
- **3 @ 20 beds plus 4 nursing home beds**
- **2 @ 28 beds plus 8 nursing home beds**
- **2@ 24 beds plus 16 bedded unit.**
- **2 @ 20 beds, 1@16 beds plus 8 nursing home beds**

In considering the various permutations for 64 beds we see that none of the options provides for the release of the £700 k plus the ability to reinvest money into the community in sufficient amounts to be confident we are providing the right levels of care. We would therefore recommend that this option is discounted.

	if we wanted to keep 64 beds we could plan it this way:								
Current staff cost for 74 Beds	community beds	number of sites	nursing home beds	cost for comm beds	Staff savings from comm beds	cost for n/h beds	add commity costs	total cost	Total Net saving
£000	Number	Number	Number	£000	£000	£000	£000	£000	£000
3500	64	3	nil	3,100	400	nil	250	3,350	150
3500	60	3	4	2,700	800	146	250	3,096	404
3500	56	2	8	2,600	900	292	250	3,142	358
3500	64	3	nil	3,100	400	nil	250	3,350	150
3500	56	3	8	2700	800	292	250	3242	258

Option 2: Fifty six beds

We have considered the following permutations of community hospital beds plus nursing home beds where needed:

- **2 @ 28 beds**
- **2 @ 20 beds plus one @ 16 beds**
- **2@ 24 beds plus 8 nursing home beds**
- **3 @ 16 beds plus 8 nursing home beds**

In considering the various permutations for 56 beds we see that none of the options provides for the release of the £700 k plus the ability to reinvest money into the community in sufficient amounts to be confident we are providing the right levels of care. We would therefore recommend that this option is discounted. It should be noted that the level of investment in the community services is higher than if we retained 64 beds, hence some savings look less than the 64 bed option. Based on these figures we would discount the ability to continue to maintain 56 beds.

	if we wanted to keep 56 beds we could plan it this way:								
Current staff cost for 74 Beds	community beds	number of sites	nursing home beds	cost for comm beds	Staff savings from comm beds	cost for n/h beds	add comm costs	total cost	Total Net saving /deficit
£000	Number	Number	Number	£000	£000	£000	£000	£000	£000
3500	56	2	nil	2,600	900	0	450	3,050	450
3500	56	3	nil	2,700	800	0	450	3,150	350
3500	48	2	8	2,200	1,300	292	450	2,942	558
3500	52	3	8	2,700	800	292	450	3,442	58

Option 4: Fifty beds

We have considered the following permutations of community hospital beds plus nursing home beds where needed:

- **2@ 24 beds plus 2 N/H beds**
- **1 @20 beds 1@24 beds plus 6 nursing home beds**

In considering the various permutations for 50 beds we see that none of the options provides for the release of the £700 k plus the ability to reinvest money into the community in sufficient amounts to be confident we are providing the right levels of care. We would therefore recommend that this option is discounted.it should be noted that the level of investment in the community services is increasing in these options offsetting any of the savings we make. We would therefore recommend that we would be unable to afford fifty beds and the right level of investment in community based services.

	if we wanted to keep 50 beds we could plan it this way:								
Current staff cost for 74 Beds	community beds	number of sites	nursing home beds	cost for comm beds	Staff savings from comm beds	cost for n/h beds	add commity costs	total cost	Total Net saving
£000	Number	Number	Number	£000	£000	£000	£000	£000	£000
3500	48	2	2	2,200	1,300	146	650	2,996	504
3500	44	2	6	2,000	1,300	220	650	2,870	630

Option 44 beds

- **1@20 beds and 1 @24 beds**
- **1@24 beds and 1 @16 beds and 4 nursing home beds**
- **2 @20 beds and 4 nursing home beds**

In considering these permutations we can see that the costs start to become affordable. Not only do we have sufficient monies to reinvest into the community but we also make the baseline savings. The two bedded unit approach can be described in seven different ways and a table is attached below to describe this as well.

	if we wanted to keep 44 beds we could plan it this way:								
Current staff cost	community beds	number of sites	nursing home	cost for comm beds	Staff savings from comm	cost for n/h beds	add commity	total cost	Total Net saving
£000	Number	Number	Number	£000	£000	£000	£000	£000	£000
3500	44	2	nil	2,000	1,500	nil	750	2,750	750
3500	40	2	4	2,000	1,500	146	750	2,896	604
3500	40	2	4	2,200	1,300	146	750	3,096	404

options	**20 bed unit**	**24 bed unit**
1.	Ilfracombe	South Molton
2.	Ilfracombe	Holsworthy
3.	Ilfracombe	Bideford
4.	South Molton	Holsworthy
5.	South Molton	Bideford
6.	Holsworthy	south Molton
7.	Holsworthy	Bideford

Option 40 beds

This is the final option and is felt to be the minimum number of beds we should contemplate at this stage. This does not mean at future dates this should not be reconsidered but allows for some flexibility and acknowledgment of the degree of change needed in the community. As can be seen the level of investment in the community services increases again to offset bed closures.

- **2 @ 20 beds**
- **1@20 beds and 1 @16 beds plus 4 nursing home beds**
- **2@ 16 beds plus 8 nursing home beds**
- **1@ 24 beds and 1@ 16 beds**

	if we wanted to keep 40 beds we could plan it this way:								
current staff cost for 74 beds	community beds	number of sites	nursing home beds	Staff cost for comm beds	Staff savings from comm beds	cost for n/h beds	add commity costs	total cost	Total Net saving
£000	Number	Number	Number	£000	£000	£000	£000	£000	£000
3500	40 beds	2	nil	1,800	1,700	nil	850	2,550	850
3500	36beds	2	4	1,800	1,700	146	850	2,796	704
3500	32 beds	2	8	1,800	1,700	292	850	2,942	558
3500	40 beds	2	nil	2,000	1500	nil	850	2850	650

Again there are a number of scenarios which enables these options to occur. These could be designed as two equal twenty bed units or one with twenty four and one with sixteen but attract different costs.

	20 bed unit	**20 bed unit**
8.	Ilfracombe	south Molton
9.	Ilfracombe	Bideford
10.	Ilfracombe	Holsworthy
11.	Holsworthy	Bideford
12.	Holsworthy	south Molton
13.	south Molton	Bideford
14.	Bideford	south Molton

And then one sixteen bed unit and one twenty bed unit:

	24 bed unit	**16 bed unit**
15.	Ilfracombe	South Molton
16.	Ilfracombe	Holsworthy
17.	Ilfracombe	Bideford
18.	Holsworthy	South Molton
19.	Holsworthy	Bideford
20.	Holsworthy	Ilfracombe
21.	South Molton	Ilfracombe
22.	South Molton	Bideford
23.	South Molton	Holsworthy
24.	Bideford	Holsworthy
25.	Bideford	Ilfracombe
26.	Bideford	Bideford

Appendix 5

Further descriptions of the suggested criteria to be used when determining the bed locations for the community.

The options must demonstrate their impact on reducing inequalities	
Why?	Northern Devon has many challenges in terms of deprivation. Rural deprivation is a key issue and there are pockets of poverty. The option must make sure it does not make deprivation worse and where possible help to address some of the impacts of deprivation.
How would we measure this?	Deprivation indices are readily available and these can be ranked for each community.
Current thinking	This is one of the key aims of the CCG, that in developing services and making changes we should aim to reduce inequalities or at the very least avoid impacting negatively on them. The most recent strategic direction for the NHS reinforces the importance of this aim.

The options must demonstrate their positive impact on 'protected groups.'	
Why?	There are groups of people who can be adversely disadvantaged by decisions made by the NHS by the nature of certain characteristics. We are obliged by law, and because it is the right thing to do, to consider if there are actions we can take which may impact more positively on these groups to enhance their ability to be helped. Groups who may find they are disadvantaged could include older people, young people, people with physical and mental disabilities, carers, black and minority ethnic groups, males or females, faith groups etc.
How would we measure this?	We would complete a limited equality impact assessment for each of the options to explore what the impact would be.
Current thinking	We should include this as we should always make every effort to act positively and proportionately on protected groups. This is a legal requirement.

The options must reflect where we think the locations needs to be to meeting the changing demographic.	
Why?	The hospital based beds will be used as a community wide resource and beds won't be so closely aligned with towns as they currently are, however it makes sense to consider if some locations may be more useful than others considering that the users of community beds is mainly the over 65's.
How would we measure this?	We have data regarding overall projections of increasing elderly population for the county but community changes are more sensitive and more likely to be affected by planning and building fluctuations. Population's percentages of older people may show increases but absolute numbers need to be included as well.
Current thinking	We do need to acknowledge that the increasing population will have an overall impact on the demand on NHS resources, although we would hope by proactive measures that people remain healthier for longer. There is new research available from Oxford University and this supports a general consensus that older people are becoming fitter and it doesn't always seem to be inevitable that an older population is necessarily a greater user of healthcare services as previously assumed. There may be a counter argument for the justification for beds as this is the most costly of NHS provision and we should be looking for models for the future that minimise our reliance on a bed based care.

Closeness to other hospitals where beds based care could be provided.	
Why?	The public view is that beds should be spread across the community, to reduce the travel for as many people as possible. Therefore proposals which cluster beds in smaller options are less favourable as they are deemed to be less accessible.
How would we measure this?	The distances between units can be assessed, using distance and travel time. These can be weighted depending on our view of the information.
Current thinking	We can understand why this may be felt to be important but this implies that beds are used for the same functions in acute hospital care and community beds which are not the case. Therefore the placement of beds as distances most geographically spread may not be relevant.

The private sector availability in terms of care homes and social care will be important influencer but the potential to increase or incentivise the market is as important.	
Why?	Some of the options include using care homes to provide some of the bed based care. The availability of care home bed services of sufficient quality is important to the public and the NHS. The current availability of care homes should therefore be factored into the options. The quality of care can be reviewed and supported by the CCG with their care home support plan. The unknown quantity is the developing care home market and the stability of the existing market. This issue is largely considered in the numbers of care home beds recommended in the first part of the process leading to a maximum of eight beds purchase at any one time. Plans can be reviewed to consider population changes and expectations around land allocation for care home provision but this will be tentative.
How would we measure this?	A snap shot is possible at any time combined with an oversight of care home planning applications or pipeline planning information and a judgment of the developing market work and its progress.
current thinking	there are some areas of the locality which have been notoriously difficult to secure community based domiciliary care and care home support which has to be acknowledged, it could be argued that the overall plan to minimise the number of care home beds to be used reflects this but some communities are more challenged with regards to access than others.

The quality of the building stock and the condition of the facilities	
Why?	The availability of funds for capital build and planned maintenance in the NHS is limited. Planned preventative maintenance is now limited to high risk areas such as electrical systems and water systems. A judgment of the quality and condition of the each of the buildings, any anticipated major costs should be considered as should the adaptability of the building for refurbishment plans
How would we measure this?	Assessment from NDHT estates services.
current thinking	Important issue for the NHS as this reduces in year revenue costs and will also have an impact on the cost of future reconfiguration.

The impact of lost opportunities – i.e. is there an alternative plan for the use which could create greater benefit for the community which would be stopped?	
Why?	The NHS can offer the facility for health and social care development for the future, and if more appropriate can work through a way of offering the facilities to the local community. In each community there is interest in developing more community based services and providing a home for services which would benefit from being more closely located with health and social care, especially voluntary and community sector groups and other health providers.
How would we measure this?	may be subjective – for further consideration
Current thinking	This means that hub development is connected with the loss of beds which may not be the right connection to be made. Hub development including health and social care and the voluntary sector opportunities should be independent of the loss of bed space and we should look for opportunities wherever they may be in the locality and not omit areas which do not currently have beds.

This option allows us the best degree of flexibility for period of surge.	
Why?	Each of the units does potentially have the capacity to increase the beds in the unit in the event of a surge or unexpected change, there will be a cost associated with any changes or increases but this criterion reflects the ability to flex our service if it was felt to be needed.
How would we measure this?	A considered view from NDHT about the actual environmentally allowable bed spaces and the ability at which they can be converted to useable spaces. This may need to be connected with the ability to recruit staff to cover the additional bed capacity.
Current thinking	This is felt to be important in view of the surges in winter escalation which have occurred although North Devon appears to be more stable than most.

Number of older people living alone	
Why?	Older people living alone are worthy of particular consideration as they may not have the infrastructure or family support to offer additional care and oversight. Communities with largest numbers of older people may place greatest pressure on community services. It is important that the wide age groups are considered not just older people as hub development and an opportunity to bring more services into a community may create a greater advantage. However older people will have a considerable use and benefit from hub developments
How would we measure this?	This number is available from the national census data, should be based on actual numbers not percentages.
Current thinking	Social isolation is a really important issue identified throughout the engagement. The NHS can consider its models of care which offers a mixed approach to service delivery so that an offer of more than just an appointment is made – for example leg club models where appointments are offered with social support and voluntary and community sector involvement. it is suggested that offering a short stay in a community bed (average 28 days) with little planned proactive & preventative care and minimal follow up is not the best way to tackle social isolation and thus would not be a good argument to retain beds.

Number of carers	
Why?	Strong message received from carers and about carers that they should not be taken advantage of, and need to be offered support to enable them to continue to undertake their caring role. Often the greatest challenge is encouraging people to recognise they have a caring role and thus ask or be offered help.
How would we measure this?	Number of people who have received a carer's assessment may be a useful figure but may not truly reflect the numbers of carers who could and should be supported in each community. We could also consider using the national rule of thumb about the numbers of carers in any given population which is suggested to be 12%.
Current thinking	The statements made as part of the engagement are well received, but suggest that retaining the beds may not be the best way to provide carer support. The solution should be the development of better practice based/ community care and understanding as well as closer working with the community to develop sustainable carer support.

There must be explicit support for the care of people in the beds from the local medical community who would accept referrals for patients not normally on their practice list	
Why?	The future model of community beds is that, a bed should be available for any patient who needs the facility to meet their health needs. At the moment, GP's providing medical cover in hospitals will only accept admissions for their own patients or those for whom there is a special agreement. The model of care needs to ensure that all people receive medical care and this should not prohibit the admission of a person to a specific hospital bed. If it is felt that this model of clinical care needs to continue there must be acceptance by the practice being paid to provide care of this principle. The service must also be provided over the seven day period so that admissions and discharge can be facilitated at all times.
How would we measure this?	We would need to agree the future model of clinical care with NDHT to consider if this is an issue.
Current thinking	There are other models of providing medical cover which may mean this issue may not occur, for example direct employment of medical staff or sub-contracting with GP provider services rather than individual practices. Therefore it is not felt that this is necessarily relevant, but worthy of exploration and understanding.

Number of household with cars	
Why?	Accessibility is an issue raised by a number of people who have participated in the engagement as critical for access to services in rural areas. It could be suggested that those places where there are higher car numbers are more able to access services which are more distant, and those with low car access should be considered as a preferable location for health services. Public transport gaps have been cited as a problem and the understanding is that public transport is likely to decline further in the community unless there are potential options of creating more community and voluntary care services.
How would we measure this?	Social Trends and census data.
Current thinking	It has been suggested that whilst access to cars may be an important factor for rural communities this may duplicate some other criteria.

The local community have a track record of contributing financially and operationally to supporting health and social care in the community	
Why?	NHS service benefit from the good will of the public and some communities are in a position, and prioritise the collection of funds to support then NHS thus enhancing the services and facilities that are available.
How would we measure this?	Review spend and strength of voluntary and community spend in the past in support of local community hospitals
Current thinking	This was felt strongly by several communities but we need to question if this should be a criteria as it could be seen to disadvantage poorer communities.

Distance from NDHT	
Why?	Distance from NDHT was raised by a number of people who have participated in the engagement in such a rural area. It was suggested that distance from NDHT was an issueif more services were located there this would create greater inconvenience and a reluctance to access healthcare. Distances further from NDHT meant that patients who needed to be placed there had less chance of receiving visitors. Public transport gaps have been cited as a problem and the understanding is that public transport is likely to decline further in the community unless there are potential options of creating more community and voluntary care services.
How would we measure this?	Calculation of distance and alignment with public transport as well.
Current thinking	These criteria may be predicated on the basis that beds would not be available for people in community hospitals at all and therefore the only option would be to use an NDHT bed. This isn't the case, there is an expectation of community beds still being available in this plan although where beds have been closed the length of stay in acute hospital care is marginally longer but there is a greater chance of receiving care at home.

Quality of housing	
Why?	There is a view that some people are admitted to hospital, especially community hospitals because their own accommodation is unfit for healthcare or recovery. Therefore people with poor housing stock may have their health further impacted upon because of the inability to receive care.
How would we measure this?	• Housing quality indicators. • Homelessness in each community. • Delayed transfers of care data.
Current thinking	Whilst there is no doubt that there is a link between quality of housing and impact on health for certain conditions the correlation between housing quality and need for beds is unclear. Homelessness may be an issue but this is worthy of further discussion to understand how it and housing quality impacts on bed locations

Life expectancy	
Why?	Increasing number so older people with complex co-morbidity place greater reliance on the use of health and social are resources.
How would we measure this?	We understand life expectancy from public health data and also how this is expected to change over time.
Current thinking	This could be argued two ways. Increased life expectancy and therefore older people would lead to a need for more beds. This is factored into our population increased projections. Conversely the older people the greater the need to remove bed based models of care and concentrate staff on direct patient contact and treatment.

dementia	
Why?	evidence would suggest that the increasing burden of dementia and the impact on the ability it has for people to live independently and safely may have a greater impact than older people numbers per se.
How would we measure this?	• dementia diagnosis figures • National predicated number of people developing dementia (to capture undiagnosed need).
Current thinking	This would be felt to be an important issue as it would affect the number of people safely managed at home and will challenge the impact on carers in these instances. It may also then influence the model of community care with more health and care support workers for the teams.

disease burden	
Why?	Those communities with the highest disease burden are likely to have a greater need for hospital beds and community services.
How would we measure this?	disease burden index available for each community
Current thinking	It is unclear whether this criterion is more relevant to community hospital or acute hospital bed requirements and would need to be explored further.

Ability to recruit and retain staff in units	
Why?	The units will only be sustainable if we can recruit and retain enough staff to avoid reductions in bed numbers because of gaps.
How would we measure this?	We would need to consider if particular areas appear to have more difficulty recruiting because of other career opportunities, isolation or other factors. We would anticipate that NDHT could provide details on this.
Current thinking	Recruitment is a general challenge in the northern locality for NDHT although various options to improve recruitment have bene successful. The options for improving recruitment may also include other models of care which combine or offer various portfolio opportunities for clinicians which are much more attractive. It may be considered that this is a common problem not exclusive to one community but further dialogue would be important as this is a critical consideration.

APPENDIX 6

Subgroup of the locality board

Bed modelling decision making process

Background to the rationale for the group

The Northern Locality Board is the board delegated by the Northern, Eastern and Western Devon CCG to make decisions pertinent to healthcare for their resident population. The Northern Locality Board is correctly constituted and includes five GP members and all members of the board have their interests documented.

The Locality board is charged with making decisions around the future model of community services which are described in the strategic direction of the CCG. This is described in the 'Integrated personal and sustainable: community services for the 21st Century' – The CCG strategy for community transformation. The complex care stream of this work considers the role and function of community hospitals and their role within community services for the future. The board is required to make decisions around the number and location of community hospital beds for the future. The board members are mindful of the following guidance:

"For the purposes of Regulation 6 [National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 20137], a conflict will arise where an individual's ability to exercise judgement or act in their role in the commissioning of services is impaired or influenced by their interests in the provision of those services."

Monitor - Substantive guidance on the Procurement, Patient Choice and Competition Regulations (December 2013)

GP members of the Locality Board have been voted to act on behalf of the member practices and the Locality Board will make the decision regarding the number of community beds for the future as part of the overall plan for integrated community services.

The decision around the location of the beds will be the most challenging, and the GP's in the group are conscious of two issues:

- Whilst representative of the locality they do not represent directly all of the affected communities and there could be a challenge of unfair advantage or disadvantage.
- A number of the GP's provide contractual services to NDHT for the management of patients in the community beds and thus could be deemed to be an indirect pecuniary interest.

Purpose

With these two points in mind the locality will set up a time limited sub group of the locality board, their core purpose will be to:

- Ensure that no one area of the locality is unduly advantaged or disadvantaged in the process determining the locality of beds.
- To assure that the process for determining the beds is rigorous and transparent
- To make a recommendation on the future configuration of community hospital beds for the northern locality to the locality board, which will then be the subject for formal consultation.

Group membership

It is suggested in the spirit of complete transparency that the membership should consist of:

- Up to four GP's or practice managers (members) not affiliated with any community hospital locations from the Northern Locality.
- The patient and public representative for the locality board.
- The patient safety and quality representative of the locality board
- One GP external to the locality.
- The group will also include a manager from the locality board not directly involved in the process. A chair will be agreed by the group.

Meetings

The expectation is that the group may only be brought together once or twice to receive the work of the larger group undertaking the criteria selection and weighting to receive the outputs of the modelling.

Decision making

It is expected that the output of the bed modelling will be unequivocal and the role of the group will be to check the process, and be reassured that the output has been arrived at in a transparent and objective way.

These outputs of the group will be presented to the locality board that will be responsible for making the final decision to commence public consultation in advance of a final recommendation the governing body of the CCG.

The locality board is not expected to vary the information they receive but could choose not to make a decision to proceed with the consultation if there are other factors which impact on the decision.

APPENDIX 7

Gateway process for the closure of beds in the Northern Locality

Draft model

Introduction

This process is described to reassure both providers of services, commissioners and public that the operational implementation of the bed closure plans will be a safe. The gateway process of review can be planned to occur as many times as felt necessary to provide evidence that the community is ready to proceed with the next stage of implementation. The questions described below are a first draft for consideration but intended to demonstrate that all aspects of the implementation plan are being covered.

	CHECKPOINT QUESTION AND STATEMENTS FOR COMPLETION	**when**
STRATEGY & PRINCIPLES AND ENABLING WORK	Is there a signed concordat which prevents one organisation proceeding with the plan unilaterally?	implementation
	Is there a clinical and operational consensus on the functions of the model and configuration of community teams incorporating primary care and the voluntary care sector?	implementation
	Do we have detailed knowledge with regards to investment, wte and skill mix across the locality and a plan for achieving this?	implementation
	Have providers and commissioners agreed a set of key outcome measures and how these will be recorded and monitored	implementation
	Is there a shared dashboard which describes outcomes, activity and productivity measures and provides evaluation measures?	implementation
	Do we have clarity of the financial model for community services and do we have enough resources to deliver it?	implementation
	Have we agreed a roll out plan for implementation, which has due regard to the operational issues of managing change but does not pre-empt the planning process.	implementation but all check points
	A review is undertaken to check that the plans still fit with local and national strategic direction.	implementation

		but all check points
	The evidence base for the change still fits.	implementation but all check points
CONTRACTUAL	New models of contractual design are considered in line with strategic approach of the NHS	implementation but all check points
	any decisions about longer term delivery of specialist community services are being enacted in an agreed timescale	Implementation but all check points for review.
	Specifications for new services are completed. Where they are not complete there is a shared understanding of priorities for completion and appropriate memorandums of understanding signed off for the avoidance of any confusion.	agreed priority of specification development at implementation and timeline
	Contractual levers are considered to support implementation.	October 2015 to contract sign off.
	The changes intended in the community design are contractualised (even if only by MOU in in first instance)	October 2015 to contract sign off.
MOBILISATION	There is a robust and stable operational managerial model and leadership to support the implementation	implementation but all check points
	There is a clear communication plan for providers and the public describing the process and retaining their involvement in community development, especially around hub development.	implementation but all check points
	There is an oversight and steering group in place	implementation
	The points for gateway review are agreed	implementation
THEMES FROM CONSUL	The needs of people with palliative and terminal care are identified and planned for. Optimal care is describable. work completed in advance of implementation and incorporated into plans above for community teams	implementation
	Domiciliary care provision is strengthened through new procurement and extended capacity. There is a clear understanding of the capacity and gaps in the northern locality and a baseline agreed for current levels and required levels to meet the changed model of care. There is evidence of active move towards	Implementation – stock take complete and at

	obtaining optimum levels of care.	all checkpoints.
	Do we have a comprehensive & joint communications and engagement plan agreed?	implementation
	Care home support is built into the community specification and the care home market is better understood and supported.	Implementation and all checkpoints.
	Staff recruitment and retention issues are adequately addressed with a comprehensive plan, and where there are known or expected difficulties innovative staffing models to be explored.	implementation requires baseline
HUB DEVELOPMENT	Baseline assessment of services provided in each current community hospital described	implementing
	Through community sector development support for carers is enhanced in each community	implementation and at agreed checkpoints
	Exploration of the hub concept for communities without community hospitals	at agreed checkpoints
	Plans for each community hub are consulted upon.	at agreed checkpoints
	Roll out plan for hub development including property issues etc. are agreed	Implementation – description of roll out plan to be agreed.
IMPLEMENTATION	Is there a need for a further Equality Impact Assessment?	implementing
	Are the mechanism for the continual engagement being honoured and any findings being fed into the planning?	at all subsequent checkpoints
	is there an need for formal consultation as part of the implementation process and has this been factored in.	all checkpoints
	Has the previous step in the plan been evaluated and is the outcome good?	all checkpoints
	Were there any lessons learnt which need to be added into the future plan?	all checkpoints
	Have we captured patient experience as part of the process and does it support the roll out or do we need to make amendments?	all checkpoints
	Are the strategic aims of the NHS and the CCG still being met by this plan?	all checkpoints
	Are their unintended consequences which need to be addressed before the next stage occurs?	