HEALTHY PEOPLE
living healthy lives
in healthy communities
Northern Devon

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Transforming Community Services:

Proposed Commissioning Intentions for the Northern Locality

Care Closer to Home

Contents

Executive Summary

This document is produced for sharing with our residents and member practices. It describes the work we are doing to ensure a safe, high quality and sustainable community health service in North Devon.

We have been thinking about, and sharing, our work about future services for some time and we call this Care Closer to Home. The Northern, Eastern and Western CCG, of which we are a part is taking a wider view across the community and have issued a wider strategy document known as Transforming Community Services (TCS).

The local Care Closer to Home work and the CCG wide work are coming together and we are pleased that those issues which are important to our communities has been replicated in the CCG strategy document.

The next stage will be challenging; people will want to know what this means for them, their family and their community. We hope this document helps share the information we have collected, and the options we may have for the future. We still need your input and are very appreciative of all the information and ideas you have already shared with us.

It is essential that the planning is made in the context of the financial climate for health and social care, which will have an inevitable impact on our future. While this will mean some difficult conversations and hard choices, we hope that you will work with us in making the right decisions for North Devon. Due to the financial situation of our health economy in Devon, there is a need to commission differently. This will include the decommissioning of certain services. Our work however is evidence based and we have used modelling and costing to inform our proposed intentions and the difficult decisions we will all have to make.

This document does not attempt to pre-empt short term measures implemented by local providers for safety or staffing issues. Neither should provider decisions pre-empt proposals in this document and decisions arising from it; TCS with Care Closer to Home is a CCG strategy, for 2014/15 and beyond, it is independent of local providers initiating change in the short term. However, we continue to work closely with our main provider, NDHT, and recognise their on-going work around community services and the challenges they face.

1.0 Foreword

Work continues in the Northern Locality of the NEW Devon CCG to plan the future shape of community services. The NEW Devon CCG published its Community Services Strategic Framework May 2014 (found at https://www.newdevonccg.nhs.uk//involve/community-services/101039). Following the publication, an 8 week period of 'listening' then began, during which GPs, the public, patients, carers, the voluntary sector, partners, providers of care and others were asked for their views, thoughts, ideas and concerns about the strategy, in preparation for the final report for the CCG Governing Board on the 4th of September 2014.

Our CCG draft strategy sets out intentions to achieve integrated, personal, sustainable, up to date community services which relies on us all working together (organisations, patients families and communities). More than ever, we know that care must be patient centred, wrapped around the individual to meet their needs, as well as those of their carers. The CCG's TCS strategy therefore considers 6 strategic priorities:

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

For further detail of the TCS strategic priorities, please see appendix 1.

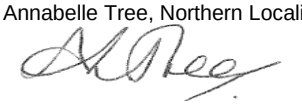
These are important whether the care is planned or more urgent and our priorities aim to meet this vision. Partnerships will be pivotal to the development and design of future services, and we may find that we need to develop new and different partnerships to ensure delivery for patients.

We have set out our commissioning intentions in line with our CCG strategic framework. This document outlines possible scenarios and commissioning proposals for 2014 and beyond (for the Northern locality). However, to ensure complete transparency, during our process from September 2014, the CCG hope to discuss community care in the event of *further* potential changes to healthcare delivery over the coming years. With community teams taking on more and more work, plus potential changes to national policy and financing of healthcare, the need to care for patients in community hospitals may reduce even further. We want to have an honest debate about this and hear what communities and GPs feel about long term plans for healthcare in communities. Should we do even more than we are currently proposing?

John Womersley, Northern Locality Chairman

Stephen Miller, Northern Locality Vice Chair

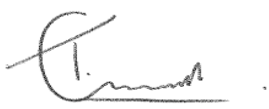
Annabelle Tree, Northern Locality Board GP



Darunee Whiting, Northern Locality Board GP

James Szymankiewicz, Northern Locality Board GP

Tim Chesworth, Northern Locality Board GP



2.0 Aim of the Document:

The aim of the document is to share our ideas for delivering care in the future. We have worked with public health information to incorporate knowledge about a town's specific needs, how the population may change over the forthcoming years, listened to community views and taken in to account evidence and national policy to inform how we plan for tomorrow, not just today.

We aim to describe a model where community healthcare is more closely integrated with social care. We must have a greater focus on health promotion and ill health prevention, where more resources are shifted from traditionally acute services into modern, efficient community services.

We are also sharing some of the work undertaken between the NHS providers of healthcare in the county with the CCG on the financial position. We are identified as one of the most financially challenged communities in the country and what is clear is that the cost of the current service we provide is not affordable now and the gap will become greater over time. This is not a good position to be in and creates a risk of short term solutions being implemented and rapid changes taking place in healthcare which are not tested or planned fully.

We have set out our commissioning intentions in line with our CCG strategic framework. The 4 main areas of care the framework identifies are:

1. Prevention and personalised support
2. Pathways for people with complex needs
3. Urgent care in the community
4. Community specialty services

In order to describe these areas of work, we have discussed them *throughout* our document.

3.0 Why Care Closer to Home?

Our previous document, 'Care Closer to Home: Engagement Document can be found at https://www.newdevonccg.nhs.uk/northern/care-closer-to-home/100955 Here, we described the programme in detail, the demographics and challenges we face in North Devon and why we are so passionate about moving care closer to home for as many people as is safe to do so.

Other Influencing factors have been taken into consideration, such as the population of North Devon and themes that came out of our extensive engagement work during 2013-14.

We would encourage you to read this document, but here it is crucial to remind ourselves of the key 3 reasons for implementing Care Closer to Home.

- **Quality;** national guidance and evidence demonstrates care closer to home will deliver as good, if not better, care for our communities. It allows us to commission individualised care around the patient, their carers and family; our primary focus is on the patient and delivering high quality care. Quality is the single most important reason for any change we implement and links to our second reason for this direction of travel:
- **Safety and staffing issues**. We do need to think carefully about our provider's ability to staff teams safely to care for the population. It is important that care is provided by the right skill mix and numbers of staff to keep our patients safe at all times. We also need to think about the effect of small groupings of staff where there is less resilience in times of sickness and vacancies.
- **Current financial position**; finally we cannot avoid our current and projected financial circumstances. We have a system wide challenge affecting providers and commissioners in

Devon and have been highlighted as a 'distressed health economy' (NHS England, 2014). We cannot afford everything we do currently. In an ideal world, where there were no financial restraints, we would have all services in all towns, but this is not possible. Neither is it an effective use of resources. We need to be more efficient and target greatest need rather than follow historical patterns of care and our 5 year strategic plan reflects these. This plan can be found at: https://www.newdevonccg.nhs.uk/

Our challenge and responsibility as commissioners is to ensure we commission high quality, evidence based care for our whole community, not just a minority, but within our financial envelope.

In North Devon, we have modelled where we could increase community services to maintain high quality care if beds are reduced or removed; there still is much to do, but we are demonstrating that we are able to effect change for the better. However, we need GPs, patients, carers and others in our communities to support us to deliver this, not just to prevent a worsening financial position, but to help develop services for changing communities.

4.0 A Vision for Community Services

Prevention and personalised support
Pathways for people with complex needs
Urgent care in the community
Community specialty services

Using the information shared by the public, we have developed the following ideas about our community needs and linked them to the above four key areas of care the CCG have identified. This section has been developed following engagement with the public, GPs and others. Having also reviewed national and international guidance and evidence, we would like to commission care in the following ways, but now ask for your feedback and views on these before final decisions are made.

4.1 Prevention and personalised support:

Increase emphasis on services that support and promote self-care and self- management.
People tell us they want to take back control of their health. Currently, patients and carers tell us that care is often fragmented, for instance they have to tell their 'story' several times to different nurses and doctors. Using a model called The House of Care we hope to commission services that help to ensure a patients care is individualised and runs smoothly. This work would include how we support and value **carers**; projects that actually deliver for carers are fundamental to a fully functioning, effective community model of care.
(see http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf)

Improve working with voluntary sector organisations.
Voluntary groups are doing immeasurably important work for communities, but the totality of services requires mapping and communicating to ensure every organisation delivering services is supported and their potential maximised.

4.2 Pathways for people with complex needs:

Develop Health and Wellbeing Hubs or centres within local communities
A hub is a building that supports services specifically tailored to its community, a place where health and social care needs can be met nearer to home. They may not contain overnight beds, but may have day beds/ chairs for day procedures. Services may include a range of options depending on local community need for example outpatients, intravenous therapies and other interventional therapies traditionally given at an acute hospital site, but the need of the community will determine what their hub contains.

Increase community based nursing and therapy staff.
This proposal is being demonstrated as popular by our engagement, but also a pilot project in Torrington is showing us how it can work. The public and GPs told us the service worked well 9-5, but out of hours the service was not at the required level. As a result we have increased nursing and therapy availability in some areas with really positive effects, extended hours into weekends and evenings help to provide continuity of care and support for the patient. This also supports those unqualified staff working in our community such as home care workers, as well as professionals such as GP's and ambulance crews.

Avoid unnecessary hospital admissions.
We know that improved community services and infrastructure enables patients, their families and clinicians to consider caring for people in a home environment. We would like to understand more fully where an increase in teams and support networks could reduce admissions to hospital, thus enabling us to shift money from hospital based care to the community.

Bring senior medical support out of hospitals and in to the community alongside GPs.
In order to ensure greater community senior leadership, senior medical support investment is paramount. GPs are central to our health needs and already leading in our communities; we must ensure we commission services that support our leaders. Innovative ways of delivering this could include *community* geriatricians.

Excellence in home based end of life care.
The majority of people wish to be cared for at home surrounded by loved ones and in familiar settings. Where people cannot be cared for in their own home there is a real desire to keep them in their own community if we can, perhaps by using local residential and care homes, through 'spot purchasing' when needed.

Co-ordinate integrated care through single points of access
We know that we could do far more to help and support health and social care staff working in the community by providing better co-ordination. This allows them to be in closer contact with each other which should encourage better care for patients and their families. We would like to explore the opportunity to further develop coordination to improve communication and the best use of staff. We need to do much more to ensure health and social care are consistently joined up. Our use of joint funding and, in the future, some patients being able to use personal budgets to purchase their own care, presents opportunities to expand our joint working between health and social care.

Our links to social care are evident. Devon County Council's (DCC) proposals to close and merge services include residential care homes and day centres across North Devon has required the CCG to remain in close contact with our DCC colleagues during this process. We feel reassured that, whilst the council have also had to make 'tough choices', due to the current financial situation, their impact assessments show they have assessed how people can still access day or residential care if they require it.

However, we have heard and understand that GPs feel concerned about insufficient or inconsistent domiciliary care being available to their patients at home when they are unwell. During the transition phase of Care Closer to Home, if there is a situation where domiciliary care is not sufficiently in place, a patient may need to stay a little longer in the acute hospital. We do not envisage this will be a significant number of patients from our pilot work in Torrington. Also, by using the BCF (Better care Fund), we will be developing further integrated care systems that ensure domiciliary care is available for patients at home who have a health need. We want to continue this discussion with GPs during our engagement period, starting September 2014.

4.3 Urgent care in the community:

Develop innovative urgent care services
The new 111 service offers a route to get advice about the right solution in urgent situations. This will help to direct people to the best place for urgent care which may include the care coming to them.

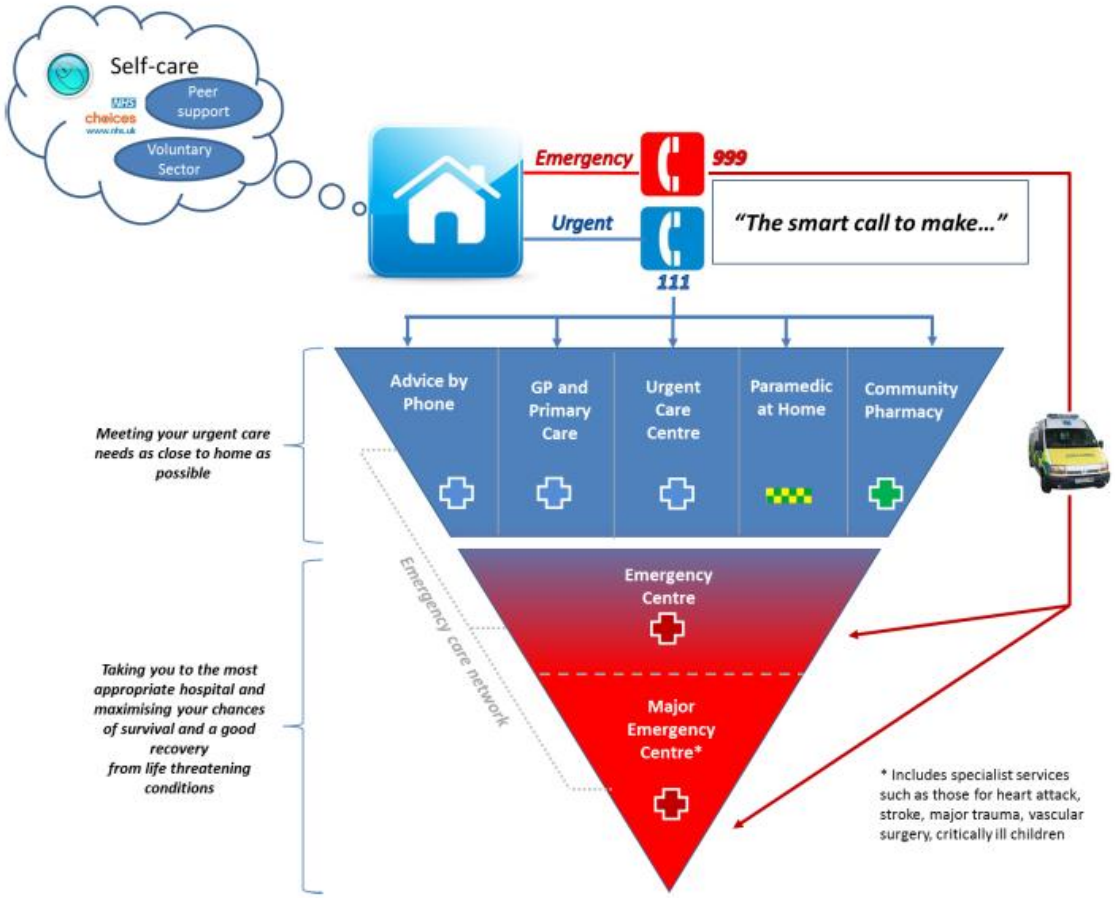
We would like to make changes so that a number of our urgent care services integrate even more than they do today. We are keen to explore all options including self-care, and the use of all health and social care professionals in order to offer the right care. There is national guidance (Keogh) around models of care, including new Urgent Care Centres which are much more comprehensive than our current minor injury units. Keogh recommends Urgent Care Centres be alongside the Emergency Department (ED) in urban areas, but also recognises the challenges this design may bring to rural communities. There are some key requirements for these urgent care centres which will be difficult to offer in North Devon such as the expected opening times and level of infrastructure required. This could make them poor value for money in a rural setting. However we need to carefully consider how we provide urgent care in the community and would like to consider some different types of models working with those clinicians already working in the community such as our ambulance services and GP's and nurses. We are also very conscious that summer visitors have a high impact on these services.

We now go into more detail about our proposals for urgent care:

Urgent Care Services are in a state of change nationally. This will drive change in the locality. Keogh Urgent and Emergency Care Review Stage 1 and stage 2 is a key driver because of their recommendations. For example, local impact derives from the statement:

"40 per cent of patients who attend an A&E department are discharged requiring no treatment. Many of these individuals could have been helped just as well closer to home, for example at their own GP's surgery or a local GP run Urgent Care Centre, provided the services were accessible and convenient"
(Found at http://www.nhs.uk/NHSEngland/keoghreview/Documents/UECR.Ph1Report.FV.pdf

Figure 2: The proposed look and design of the new system.



(Keogh, 2013. Available at: http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

There are several items within Keogh that "Chime" with Care Closer to Home:

- **Improved reliable support for people on the telephone: -** a clinically-rich 111 service being refined in Devon.
- **Better use of pharmacies: -** not as well developed in the Northern locality but there are already several 100-hour pharmacies across the locality.
- **Paramedic at Home:** South Western Ambulance Service (SWASFT) recognise the issues of a rural population and have for a number of years worked to help people avoid a hospital admission with a clinically safe alternative. In a rural dispersed county such as Devon they present a prime opportunity to work with Care Closer to Home and avoid admissions.

Other aspects of Keogh present challenges to the Northern Locality:

- **Increased access to your own GP:** Clearly, the most basic "unit" of Care Closer to Home after the patient's own home is the GP surgery and the patient's own GP is an integral part of Care Closer to Home with much of the actual work undertaken by a Community-based team.
- **Urgent Care Centres instead of Minor Injury Units (MIUs):** Keogh highlights a number of problems with MIUs that we recognise apply to those MIUs in the Northern Locality:
    - **Issues over skill-mix:** many attendees are "minor-illness" not minor injury.
    - **Variable opening hours:** often low numbers make over-night opening non-viable.

- **Variable "offers":** MIUs vary quite a lot and patients can't reliably know what will and won't be dealt with in any single MIU.
- **Lack of important diagnostics:** e.g. plain x-ray to rule out fractures.

Many of these issues relate to viability of a service when there are low numbers of patients attending. This is a particular and key problem for the Northern Locality which covers a large area but has relatively low population numbers. The replacement suggested by Keogh is a standardised Urgent Care Centre (UCC), but these are also based on population/demand numbers and on first appearance none of the current MIU's would safely make the transition to being an UCC and remain clinically or financially sustainable. Also recent work by the Primary Care foundation does not show a reduced workload for either GPs or A&E in communities that have an MIU. We anticipate that the current model of minor injury units would disappear but alternative urgent care services would need to be considered.

Out-of-Hours (OoH) Primary Care Re-Procurement: Devon Doctors Social Enterprise has provided an excellent, clinically evidenced and safe service for a number of years. Notwithstanding this, the contract was first specified some years ago and needs updating.

- Care Closer to Home: we must integrate the evening and overnight parts of Care Closer to Home with the OoH Primary care work using community and ambulance staff to allow the GPs to do what they do best.
- 111: can be developed to robustly handle the telephone advice aspects of patient demand in and out-of-hours.
- The growing developments in both equipment and skills for the ambulance service which follows the Keogh recommendation to see ambulances as Mobile Treatment Centres.

4.4 Community specialty services:

Make more Specialist and outpatient services available in the community:
NEW Devon CCG is currently undertaking a review of community based specialist services across Devon, which will inform our work in North Devon. We want to understand the individual needs of each of our localities and see how many specialist clinics we can draw out of the acute hospital and deliver closer to home. Services under review include the bladder and bowel service. We are interested in community views to determine which specialist services should be prioritised for review in our community as creating the most positive impact for the public.

5.0 Further Key Points to Consider

5.1 Primary Care:

Changes in the proportion of care provided in community settings naturally creates concerns for primary care teams who have responsibility for oversight and management of care. Whilst for example the Torrington test of change does not so far appear to have demonstrated an overall increased workload, improved care co-ordination and communication, as well as increased community staff to wrap around the patient and primary care, appears to have helped this. We are not suggesting that the changed models will not have an impact on primary care but our questions are more related to 'how and by how much? We would like to work with practices and the NHS England who are responsible for commissioning primary care to explore how primary care could be supported to be confident that changes will not have any significant adverse impact.

5.2 Review the clinical and economic value of Community Hospital Beds:

Community Hospital beds can prove to be an expensive way to deliver care to a small number of people. Whilst necessary years ago, clinical expectations and expertise have changed and now

there is a much smaller cohort of patients who really need the services that community hospital beds can provide.

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

1. 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.

2. 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.

There is a third group of patients who no longer have a medical or nursing need, but do have a care need as a precursor to being fit for rehabilitation or returning home. An example would be a person with a full leg cast. These patients need care but don't need to be in a hospital and we are increasingly caring for these patients by purchasing their care from care homes, allowing them to be as close to their own home as possible but enabling their care to be professionally delivered and not relying on family when that is inappropriate.

We have listened carefully to the community concerns about retaining community hospitals and for the patients described above we would want to keep community hospital beds. However, we cannot afford to keep them all, nor do we need to. One of the questions this paper raises is how many beds do we need and where are they best placed?

We understand that the issue of community hospital beds is a difficult and heartfelt one. However, we have reviewed how well the current community hospital beds are used – when, where and by whom and for what. We would make the following observations:

- Community hospital beds in the past have been used to deliver respite care, often in the absence of adequate social care. Social Care has a duty to provide respite care for those eligible. As respite care will not require nursing or medical care it should not be delivered through a hospital admission.

- Community hospital beds in the past have been 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.

- Rurality and the importance of friends and family visiting have been raised as has the difficulties caused by lack of public transport. While these are really important in the personal life of anyone either in hospital or with a loved one admitted in to care, they cannot constitute legitimate arguments for keeping community hospitals open in economically constrained times. Whilst we have and continue to take rurality into consideration when making difficult decisions, it is a duty of the CCG to budget to provide *medical* care safely and efficiently for the whole health economy. Reviewing DCC and other transport routes and timetables enabled us to follow up on this concern and take this into consideration during our planning of scenarios.

- Whilst rurality and the challenges this brings (particularly in winter), were of concern to communities, the feelings attached to the buildings themselves must also be taken into

consideration; many know or knew patients, some who died in our community hospital. This passion felt for our local hospitals must be acknowledged, but we cannot continue to do everything. In order to care for more patients to a high standard, we will need to make difficult choices together- GPs, commissioners, providers, the public.

- Winter resilience of enhanced community care. We have received several comments expressing concern that an enhanced community service would fall down in a severe winter. We acknowledge that all health services struggle in the winter months and home based care for patients who live along narrow un-gritted lanes may be challenging for a few days each year. However the number of additional patients cared for through the enhanced community service proposed is small even though they may be receiving care several times a day. Part of our planning does and will involve how we manage these patients in severe weather (operational resilience capacity plan).

- There has been a common misconception about the function of community hospitals in terms of their ability to provide emergency care. The belief that a community hospital has a part to play in emergency care is misplaced and anyone in need of emergency care should rightly present to emergency departments or urgent care centres which community hospitals cannot deliver.

- It is important remember that, at times, community hospital beds were used for *long term social care*, preventing GPs from admitting patients requiring nursing care due to *health* needs. We spot purchase care home beds for some of these patients when required, others remain in community hospital beds.

However, the conclusions we are reaching from our modelling is that there is a group of patients who need a community bed for clinical reasons and we also acknowledge that there is a point at which financially it becomes far more expensive for them to be managed at home..

Crucially many patients do not require bed based care; they can be cared for at home if other services are increased, such as nursing and therapies. Some of the patients we believe, from our work, do require 'bed-based' care. At the moment we have 74 beds in community hospitals. Modelling work suggests that the range of beds needed could be between 45 and 64 beds at any one time for people who meet the criteria for bed based care. These could be provided either wholly in community hospitals, or through a combination of community hospital beds and spot purchasing of care home beds.

The benefit of spot purchasing beds is we can provide beds in response to need and demand. This provides the flexibility and opportunity for offering bed based care closer to home, irrespective of the location of your nearest community hospital.

We now present our commissioning intentions that describe provision of 45-64 beds for people who meet certain criteria for 'bed- based care' and where they may be located. The examples in this document are not exhaustive and we pose the question, 'where would these beds be best placed?'

6.0 Modelling for Care Closer to Home

Our working hypothesis is that there is a cohort of patients identified in terms of clinical need that are currently treated in hospitals but would be clinically appropriate for home-based care. We have used a modelling methodology to try to predict the optimum configuration of community hospital beds and community services to test the clinical and financial viability of this model.
The key questions therefore are:

1. What is the optimum number of community hospital beds to meet the needs of the people of the Northern Locality?
2. What is the corresponding investment required for community services to serve the Northern Locality?
3. How can we best evaluate such potential major service changes?

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.

There are other parameters and assumptions to be taken in to account when modelling services.

1. Our existing community teams are organised in natural communities around clusters of GP practices; these should be reflected in service design

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

3. The Northern Locality support larger units, due to the financial efficiency they bring. Also, such units are easier to staff and reduce the risk of 'lone working' practices, thus protecting patients and staff. Staff can be regularly updated, maintain their skills and cross cover when required.

7.0 Evaluating Scenarios using the Modelling

The Northern Locality has chosen to utilise our main provider, NDHT's method of modelling, described below:

This modelling methodology allows us to assess each scenario against 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.

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.

Please note, as well as the modelling above. We have, and will continue to review public health data and undertaken further costing to help inform our decision making. Crucial to this process however is your feedback and advice.

8.0 Proposed Scenarios

Currently, the Northern Locality of the NEW Devon CCG has 74 community hospital beds (excluding specialist beds, such as stroke).

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.

The Northern Locality's proposal to commission a number of community beds within this range of 45-64 is based on acuity and on the assumption that there is robust, sustainable and high quality

domiciliary and social care provision available which is integrated with a local nursing and therapist service.

Scenarios: **We propose a reduction of community hospital beds to 40, 48 or 56 across 2 or 3 sites plus increased community services and with or without access to spot purchased beds.**

These scenarios would help to address the financial position to varying extents depending on the number of beds and number of sites. As previously discussed, the CCG support larger units of 16+ beds.

We have modelled for a range of 45-64 ***community hospital beds*** and costed for 40, 48 and 56. However, to ensure safety, we have also costed for the difference in the maximum number of 'beds' that could be needed (64) - we propose we would ***spot purchase*** these beds. This is where we would pay for a *short term* placement in a care home bed as required. For instance if 56 *community hospital beds* are commissioned, what is the cost? Then what is the cost of a further potential 8 *spot purchased beds*?

Considering the modelling data, as well as the information from engagement (such as rurality concerns) and Public Health data, we propose any of the following hospitals could currently house these beds: Barnstaple (NDHT), Ilfracombe, Holsworthy, South Molton and Bideford, in possibly 2 or 3 units. There are several possible scenarios. Below details just *some potential* options the CCG would like to consider for the commissioning of 40, 48 and 56 community hospital beds. Please note, extra beds in care homes could potentially be spot purchased as required.

The Northern Locality would like to talk about the number of community hospital beds and their location; whilst we are proposing to commission 40-64 beds, we maintain we must and will consider the benefits of less sites, such as 2 or 3, with a greater number of beds, for reasons described previously:

SCENARIO 56 BEDS	A	B	C	D	E	F
HOSPITAL	**56**	**56**	**56**	**56**	**56**	**56**
ILFRACOMBE	0	16	0	0	0	16
S MOLTON	16	0	16	0	16	0
BIDEFORD	24	24	16	24	24	24
HOLSWORTHY	16	16	16	16	0	0
BARNSTAPLE	0	0	8	16	16	16

SCENARIO 48 BEDS	A	B	C	D	E	F
HOSPITAL	**48**	**48**	**48**	**48**	**48**	**48**
ILFRACOMBE	0	16	0	0	0	16
S MOLTON	16	0	0	16	0	0
BIDEFORD	16	16	32	32	24	24
HOLSWORTHY	16	16	16	0	16	0
BARNSTAPLE	0	0	0	0	8	8

SCENARIO 40 BED	A	B	C	D	E	F
HOSPITAL	**40**	**40**	**40**	**40**	**40**	**40**
ILFRACOMBE	0	0	16	0	0	16
S MOLTON	0	16	0	16	0	0
BIDEFORD	24	24	24	16	16	16
HOLSWORTHY	16	0	0	0	16	0
BARNSTAPLE	0	0	0	8	8	8

Torrington Community Hospital: Due to major issues reported by the provider in relation to recruiting staff, along with significant investment made in the region, the community team has now been developed. Torrington is being considered separately to TCS, due to an on-going detailed evaluation and a protracted engagement process. Therefore Torrington Community Hospital has not been included within the *current* Care Closer to Home scenarios.

9.0 Costing

In order to assess the affordability of our proposal to:
increase community teams and reduce community hospital beds,

We considered:

1. The savings made from reducing community hospital beds to 40, 48 and 56 consecutively.
2. The cost of a town's increased community service requirement (if community hospital beds were removed)
3. The cost of spot purchasing beds required to ensure 64 'beds' are available.

Then:

4. The cost of increased community teams – savings made by a reduction in hospital beds = x

As expected, X varied greatly depending on the number of community hospital beds proposed, as well as the level to which each town would need to increase their community services due to bed closures.

NB. We also acknowledge the evidence that suggests that when a community team is enhanced, due to closure of the town's community hospital beds, 100 emergency admissions are avoided per 13,000 of population in 6 months. This *saved* £80,000 over a 6 month period through those 100 people staying at home rather than be admitted to hospital (Torrington Evaluation, 2014).

There may also be savings through the development of hubs, by renting space in the buildings to groups who provide services. This saving could be reinvested or potentially be part of a savings plan. The cost of the actual infrastructure (the building) is already funded so will not change.

NB. Each locality will have its own economies of scale. For instance more rural communities may have to use more fuel during the delivery of their community care. This has not been costed at this stage and requires more work and discussion.

10.0 Continuing to Involve You

This document is produced as result of engagement, scrutiny of the national evidence base in relation to Care Closer to Home, the learning from the test of change in Torrington and local public health intelligence. We would now like our member GPs, the public, other stakeholders and groups

to review and feedback on the document's proposals during our public engagement period 17 September to 12 December 2014. We have published dates for meetings and do hope as many people as possible attend and feedback, as well as GPs, nurses and others.

11.0 How to Contact Us

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For more details on the CCG's processes for Transforming Community Services please see the following webpage: http://www.newdevonccg.nhs.uk/get-involved/get-involved/community-services/101039

12.0 Supporting Information

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

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Report of the Independent Commission on Whole Person Care (2014)"One Person, One Team, One System"
http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf

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http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

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The Kings Fund (2013) Delivering better services for people with long-term conditions: Building the house of care
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

The Silver Book (2013)Quality Care for Older People with Urgent and Emergency care Needs
http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

13.0 Appendices

Appendix One:

Six Strategic Priorities for TCS

The six strategic priorities based on discussion with stakeholders reflect the need for strategic shifts in the way we commission services, deploy resources, and design care to meet the Strategic Framework.

Help people to stay well

From a primary focus on caring we would expect the emphasis to move towards prevention, self-management and early help recognising the importance of information and positive approaches in particular helping older people remain well where possible.

Our pathway design for adults with complex needs addresses this including the important role of community services in promoting wellbeing.

Integrate care

Services that are co-ordinated and integrated and that remove and minimise organisational boundaries should be a central feature for future services. The importance of services being wrapped around individuals and their families has been stressed time and again.

Our work with local authorities to strengthen integration is progressing rapidly. In addition this strategic framework emphasises the importance of integration of other services.

Personalise support

Personalisation means allowing choice and control over areas such as personal health budgets, information, education and self-management support. Personalisation is much more than personal health budgets and we need to develop a model of care that is designed for individuals.

We have tested views in a number of discussions and as a result this strategic framework increases the emphasis on flexible approaches to supporting individuals.

Co-ordinate pathways

The importance of pathway based approaches to care with co-ordination through prevention to crisis and ongoing care has been identified time and again, with a particular emphasis based on the natural flows of patients.

In addition to addressing the role of prevention, the work on pathways includes responses to crisis and ongoing care and evaluation.

Think carer think family

The key role of carers and the need to support carers' health and wellbeing in addition to that of patients and the population,

to achieve mainstream services that are carer aware become especially important as more services are focused in people's homes and in the community.

The important learning from carers is central to implementation of the strategic framework and the Carers Strategy work and continued links will guide community services.

Home as the first choice

The growing understanding of the need to shift the emphasis to fewer beds but a greater number of more personalised and responsive care packages at home gives us a clear impetus to achieve this at the earliest opportunity.

Getting the right balance of care is central to this strategic framework and will be the subject of ongoing engagement in both the planning and evaluation of services.