Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Decision-making criteria

to be used when making decisions about the location of community hospital inpatient beds in North Devon

Public consultation: North Delivering care closer to home

Version 1: July 2015

Criteria developed through public consultation

The criteria in this document are based on the outputs of NEW Devon CCG's Care Closer to Home consultation during 2014/15. They have been suggested by the public as important when making decisions on the future location of community hospital inpatient beds.

All the criteria that were suggested during the CCG's consultation are listed in this document. We now need to work with our stakeholders to detemine if and to what extent the criteria can help us make a dicision on where inpatient beds should be located in Northern Devon.

The Northern Devon Healthcare NHS Trust and NEW Devon CCG will be working with our stakeholders to review this list and agree a shortlist of relevant criteria. We will then consider and agree the relative weighting of these final criteria.

We need people to come to a consensus view of the relative importance of each of the criteria. The sort of questions we will be asking are whether rurality or access are more important issues than the number of people in the community with dementia.

Developing the options for consultation

We will then work through the process of applying these criteria to the potential options, in order to produce an option or number of options on which we can consult publicly.

Statutory obligations

As mentioned in the CCG's Bed Modelling Paper (May 2015), any options for bed location must be high quality and safe. There must be a strong evidence base for the model of care and the options must deliver safe services and excellent patient experience.

It is also important to recognise that any options must be financially affordable and sustainable. We must be able to deliver the model of care within our budget.

Finally, we must consider the workforce implications of any option: we must have sufficient staff to deliver the service and not be reliant on agency staff.

Criteria developed through CCG consultation*

Reducing inequality - a positive impact on protected groups

1. 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. Any 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.

2. 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 the impact.
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.

Care environment

3. 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 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.

* Source: Bed Modelling paper from May 2015 Board Meeting, pages 35 to 44.

4. Quality of housing	
Why?	There is a view that some people are admitted to hospital, especially community hospital, because their own accommodation is unfit for healthcare or recovery. Therefore people living in poor-quality housing 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 not usually linked. Homelessness may be an issue but this is worthy of further discussion to understand how it, and housing quality, impacts on bed locations.

5. 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 wider 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 and 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.

6. 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?	Snap shot possible at any time combined with an oversight of care home planning applications or pipeline planning information.
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.

Transport distance and travel times

7. Distance from North Devon District Hospital (NDDH)	
Why?	Distance from NDDH was raised by a number of people who have participated in the engagement in such a rural area. For example, if more services were located at NDDH this would create greater inconvenience and a reluctance to access healthcare. Distances further from NDDH could mean that patients who need to be admitted there have 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 car services.
How would we measure this?	Calculation of distance and alignment with public transport as well.
Current thinking	This criterion 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 NDDH bed. This isn't the case; there is an expectation of community beds still being available in this plan. Where beds have been closed, there is a greater chance of receiving care at home.

8. Distances to other hospitals to access bed-based care	
Why?	The public view is that beds should be spread across the community, to reduce the travel time and distance for as many people as possible. Therefore proposals which cluster beds in closer proximity 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 we need to understand that acute and community hospital beds provide very different levels of care and treatments to patients. Therefore applying a geographical criteria to the distribution of beds may not be relevant.

9. 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. For example, distance from NDDH.

Operational considerations

10. This option allows us the best degree of flexibility for period of surge	
Why?	Each of the units could potentially increase its bed capacity 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 about the actual environmentally-allowable bed spaces and the ability at which they can be converted to clinical 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.

11. There must be explicit medical support for the care of people in the beds	
Why?	The future model of community beds is that a bed should be available for any patient. 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. The service must also be provided over the seven day period so that admissions and discharges can be facilitated at all times.
How would we measure this?	We would need to agree the future model of clinical care with clinicians 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.

12. 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.
Current thinking	Recruitment is a general challenge in the northern locality for NDHT although various options to improve recruitment have been 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.

Local health and disease

13. Life expectancy	
Why?	Life expectancy is increasing the number of older people with complex co-morbidities. In turn, this places greater reliance on the use of health and social care 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 the people, the greater the need to remove bed-based models of care and concentrate clinical resources on direct patient contact and treatment.

14. 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 is 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.

15. 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.

16. The options must reflect where we think the locations need 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 are mainly over 65.
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 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 that by proactive measures, 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. This 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.

17. Number of carers	
Why?	We have received a strong message 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?	The 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 care and understanding as well as closer working with the community to develop sustainable carer support.

Other

18. 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 through health and wellbeing hubs. 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?	This is difficult to measure as to some extent it is subjective. However, it will be considered.
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.

19. The local community have a track record of contributing financially and operationally to supporting health and social care in the community	
Why?	The NHS benefits greatly from the goodwill of the public and some communities are in a position to prioritise the collection of funds to support the NHS, thus enhancing the services and facilities that are available.
How would we measure this?	Review 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 criterion as it could be seen to disadvantage poorer communities.

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