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Questions from North Devon GP Provider Group for meeting on 29 September 2015

1. **The Trust is expected to achieve £3.1m of cost reductions in 2015/16. The actual level of CIP requirement driven by the application of the national tariff deflator to community services is £5m. How much is it related to the 5 community hospitals in N Devon?**

The Trust is actually required to make savings totalling £13.1m (not 3.1m) in 2015/16.

The application of the tariff deflator and other national planning assumptions to the community element of the contract would require a saving of £3.1m, however, we recognise that the national planning assumptions do not sufficiently reflect the changes to the cost base for recent initiatives such as "safer staffing levels" (which saw lone-working and safe staffing ratios introduced to all our inpatient wards), where no national or local funding has been provided.

After taking account of these factors and non-recurrent changes to the contract value between 14/15 and 15/16, we have identified that the savings target for the community services as a fair share of the total savings target is £5m. Of this, £1.25m is applicable to the community services provided under the northern part of our contract.

The strategic direction of both the CCG and the Trust are aligned in that it is better for patients and more efficient use of resources to develop services that are more home facing and less bed-based. The strategic objectives of both organisations are supported by the evidence of the acuity audit recently published by the Public Health team at Devon County Council.

2. **How much the Trust expects to save by closing all community beds, can it be broken down by each hospital?**

The cost of each consultation option will differ but the Trust is working on the basis that each community inpatient ward saves a net £700,000 after re-investment (see answer to Q3 below).

3. **How much of this saving will be reinvested in the community services teams? How, when? What and how much? How does this value compare to what was actually spent on increasing community resource in the Torrington trial period.**

There are lots of questions within this question. The CCG does not stipulate the levels of community service to be provided by the Trust, as it is in a 'block contract'.

We work on an indicative planning assumption of £10,000 allocation per bed. The enhanced community services will utilise many of the staff currently employed in the inpatient units therefore this will be implemented concurrently as the beds close.

In terms of the how much will be reinvested in community teams this depends on the baseline of resources currently in each town and the outcome of the consultation. As you can see from the Quality Impact Assessment we intend to replace the community inpatient beds with the following (extracted from QIA):

- Increased rapid response where possible to provide an urgent response (KPI of response within 2 hours and visit within 4 hours) to enable people to remain at home - providing intensive and overnight care at home for short periods, working closely and case managed by the health and social care teams.
- Development of the Eastern and Northern Rapid Intervention Centres to be co-located with social care to provide a more streamlined and integrated response.
- Simplified referral systems for example e-referrals for planned nursing care from GPs, acute and community hospitals.
- Improved out of hours contingency planning with contingency plans agreed with individuals and their families held at the Rapid Intervention Centres for access by urgent care out of hours nurses and SWAST to prevent an avoidable admission where possible.
- Strengthened integrated multidisciplinary interventions and support providing wrap around care, including multidisciplinary weekly discussion at Core Group for people with most complex needs.
- Development of health and well-being services at the hospitals which lose beds offering increased clinics, for example: therapy and falls and balance classes within a social context so addressing needs of social isolation.
- Closer working with the local community to develop community model eg One Ilfracombe working with volunteer coordinators based within each of the community teams to refer to local groups.
- Piloting provision of health-led domiciliary care within Northern Devon to increase market capacity and closer working with personal care market.
- Development and expansion of care homes nursing team to provide support and training within care homes and safeguarding nurses to ensure quality and safety of care, as well as avoiding admissions where possible.
- Development of integrated health and social care teams at 'front door' of acute to prevent an admission and at 'back door' to facilitate timely complex discharges. Increased community led supported discharges by the community teams to proactively in reach and facilitate hospital discharge.

The Test of Change in Torridge (the funding covered both Torrington and Holsworthy) was established on a different footing and received a significant amount of investment due to historic underfunding of the community services in Torridge.

4. Could the answers for Q2 to 4 be included in the consultation to assist people to make the decision on which option to choose?

This request was made on the last day of the consultation so it is not possible to make this happen.

However, we have been asked questions about finance throughout the consultation and have published our answers here (www.northdevonhealth.nhs.uk/northconsult). Generally people have welcomed our confirmation that we have deliberately not published the 'cheapest' option as this is a consultation primarily about delivering safe and effective care, secondarily, within the budget.

5. **How will the Trust deliver current service such as MIU in the community hospitals? Will all MIUs be closed? Partly closed due to staffing issues?**

The Trust is not planning to make any changes to any MIU service. Where they are, they will continue.

GPs will be aware that MIUs are included in NHS England and NEW Devon CCG's consultation on urgent care. Whilst currently halted, providers of out of hours GP services, MIU and WICs anticipate that there will be a different commissioning intention and therefore service specification for these urgent care services.

6. **What is the contingent plan for the winter pressure for NDDH when the hospital beds are closed? Hope it is not emailing GPs every day to ask them not to send patients in.**

We have started our planning for winter now – with the Perfect Week, which starts on 30 September.

The Trust is an active member of the System Resilience group in North and East. This is led by the CCG and involves all key stakeholders to look at what actions can be taken to the most benefit in times of escalation.

When we are in escalation the CCG is required to co-ordinate a system-wide response. That necessarily involves primary care to ensure you are aware we are under pressure. If you think there are more effective ways in which you can respond to periods of NDDH escalation, please let us/the CCG know what they are.

7. **When will the Trust start talking to GPs who provide medical cover to community beds? What happens if the GPs do not want to provide the 'new form' of medical cover to the community team?**

This is called suitable alternative employment and – as with our inpatient staff – the same HR procedures apply to those GPs employed by the Trust to provide medical cover to community inpatient units. Once the outcome of the consultation is known we will meet any staff that are affected and talk through their possible options.

Some staff will know what they want to do, some will welcome support and a trial period before making up their minds. We are flexible in this regard. The GPs that currently provide medical cover to our community hospitals and who are affected by the outcome of the consultation will receive the same support to express their preferences.

8. **When do you envisage closing the beds and when will the additional community team members be in place to support the patients at home?**

The Board will make its decision on 6 October and planning will commence immediately with a view to ensuring the new model of care is safely embedded by winter.

9. **Whilst we appreciate that this has worked elsewhere in the UK, rural North Devon is a widely dispersed population with poor transport links, how will the Trust ensure that equality of access to beds is available to all (within reasonable travel time/distances)**

That rather supposes that there is equity of access to beds at present!

If you are a resident of Barnstaple, Braunton, Chumleigh, Winkleigh etc you have never had equity of or easy access to a community hospital bed.

It is for this reason that we ensured health inequalities, access and transport links were decision-making criteria in the consultation.

10. What if the trust is unable to get the additional community team members in post before the beds are closed?

An important point to make is that the enhanced community teams will come from the existing inpatient services of the hospital(s) which close(s). The transfer to community occurs simultaneously and with intensive support to ensure we avoid the counter-productive situation of making nurses redundant at a time of national nursing shortages.

11. NDDH is already on Red Alert (rather earlier in the year than last year) and closing community beds will exacerbate the problem, how will the trust ensure that this is not the case?

We have already demonstrated in areas without beds that removing community inpatient beds has no negative impact on the acute/wider system during periods of surge.

One of the specific criteria in the consultation is the ability to respond in times of surge and this has been considered by both the public, stakeholders and the clinical and operational teams during this consultation. Due to the long lengths of stay and the small bed-stock, community hospitals do not provide effective or flexible additional capacity during periods of surge. Our most effective additional capacity instead comes from extra rapid response.

12. Why is the Trust striving to balance the budget when other trusts in Devon are accepting of their overspend outturn?

Devon is already on the national radar due to the severe financial difficulties in the area. It was one of the 11 named challenged health economies in 2014 and is now one of the first three areas to go into the Success Regime. There will be immense activity to transform the way we deliver health services going forward as the Success Regime starts its work.

The funding gap will not go away and all organisations will be expected to find savings. Delaying action will make Devon's financial position worse and jeopardise our long-term abilities to provide safe and sustainable services in North Devon.