Committee/Board Report

Date	14th August
Report title	Evaluation of the Torrington Community Cares Test of Change (ToC)
Author(s)	Kerry Burton
Supporting Executive(s)	Dr Chris Bowman
Executive Summary	This is a draft document following the first discussion at the Transforming Torrington Together Task Group, now renamed Torrington Community Cares. Its purpose was to start a conversation with the Torrington community about how we would all be able to judge whether the ToC had been a success and subsequently have confidence in the consequent decisions. The aspiration is to develop a rigorous evaluation process throughout the duration of the pilot and produce a summative evaluation at the end.
Actions Requested	The Board is asked to receive the first draft as part of the on-going process of establishing a robust system of evaluation.
Which other committees has this item been to?	The membership of the Torrington Community Cares Task Group have received copies and asked to comment. Only the supporting executive has responded to date.
Reference to other documents	Transforming Torrington Together and Care Closer to Home are implied, but not referenced.
Have the legal implications been considered?	Yes
Does this report need escalating?	No
Equality Impact Assessment	
Who does the proposed piece of work affect?	Staff Patients Carers Public

	Yes	No
Will the proposal have any impact on discrimination, equality of opportunity or relations between groups?		X
Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		X
Will there be a positive benefit to the users or workforce as a result of the proposed work?	X	
Will the users or workforce be disadvantaged as a result of the proposed work?		X
Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		X
If the answer to any of the above questions is yes (other than question 3) or you are unsure of your answers to any of the above you should provide further information using Screening Form One *available from Corporate Services*		
If an equality assessment is not required briefly explain why and provide evidence for the decision.		

Transforming Torrington Together Task Group

10am, Tuesday 16th July, Torrington

Evaluation Framework – Second Draft

Introduction

It is important that the Torrington health and social care pilot has an evaluation framework that is agreed between all parties before the 1st September.

This document represents the first draft of metrics and actions that were proposed at the meeting above, and provides a basis for discussion, with a view to signing off an evaluation document by the middle of August.

(Please note, there is a glossary for reference at the back of the document)

1. How many people from Torrington and its Parishes need to be admitted to a community bed elsewhere, while the Torrington beds are unpopulated?

To make sense of this data, we would need to collect the following:

- Reason for admission
- Whether the admission was a "step up" admission from the community, or a "step down" transfer from Northern Devon Healthcare Trust (NDHT) or the Royal Devon and Exeter Foundation Trust (R,D+E)
- Length of Stay
- Impact on family, friends and carers
- Total numbers over the pilot period

There would need to be a discussion about other/additional services that might have made the difference between each admission and the service user remaining at home safely with appropriate care.

2. How can we present the information we already have about the trends and patterns of Lengths of Stay (LoS)? How can we explain what we think it is telling us?

1. There is already a wealth of information about LoS. It needs to be presented to the group for discussion. **Action** Steve Hudson.

2. There would be merit in comparing LoS previously in Torrington beds, with the average length of input from the Torrington multidisciplinary team during the pilot. To do that, the clinical team would need to agree a set of criteria that would define either:

   Those patients who would have received a step up admission, were the hospital beds being used, and/or in the absence of enhanced community services.

Or those patients who would previously been admitted to a community hospital bed after an acute admission and/or in the absence of enhanced community services.

3. It will be important to make sure residents from Torrington and its Parishes do not find themselves being kept in Acute hospital longer, due to the absence of community beds. To measure this we will need to collect the following:

    - Admission data to the Acute hospital (NDHT or RD+E)
    - Length of stay
    - Diagnosis on discharge
    - Care package on discharge (including health and social care)

There is an additional opportunity here to work up the use of the Admissions, Deaths and Discharges (ADD) daily report, with protocols in place to support patient flow.

3. What do our service users think, from their experience?

Patient experience questionnaires will be created by the task group and used during the duration of the pilot. It was agreed that the questionnaires would be left with each service user at the end of the episode of care with a stamped addressed envelope for returning them. Each questionnaire should be reviewed on receipt so that lessons learned can be actioned straight away. A summary report will be required at the end of the pilot. **Action** Katherine Allen

4. What do our carers and families think, from their experience?

- Recently, all community workers have been issued with a card to be worn with their name badge with details of carer support services.
- It is a requirement within social care that carers' assessments are undertaken.

More explicit actions need to be described for this part of the evaluation framework

5. What do the Public think of our plans?

As part of our public engagement plans, we are committed to be available and visible for the people of Torrington. We intend to:

- Hold a public Saturday morning meeting in the near future.
- Establish weekly Question and Answer sessions, attended by senior managers from NDHT and Northern Locality

6. Linking with the Voluntary Sector in Torrington; how can we work together more closely and how can we determine the benefit to our service users?

TorrAGE have already approached the Northern Locality, NEW Devon CCG enquiring about the possibility of office space in both Torrington and Holsworthy Hospitals to help draw services closer together.

TorrAGE are also putting together a "*bid for a 3 year project to provide volunteer mentors to support older people in their homes, around specific social care needs such as dementia and depression/isolation. We will be focusing 3 Key area's Torrington, Holsworthy, Winkleigh and surrounding villages. The project will be aimed at training volunteers to give them an understanding of the social care needs, and how to engage their client into the local community to prevent readmission and help keep people in their own homes*."

Action: Nikki Kennelly and Kerry Burton to explore options with Steve Reah in the first place, but not excluding the other voluntary services.

7. End of Life care; how can we assure the public and the GPs that there are the right resources and expertise in the Torrington and Parish Community, linked to specialist nurses, to enable people to die at home if they so wish, comfortably and with dignity

KB – There was a review published on 15th July 2013of the Liverpool Care Pathway (LCP), which has 44 recommendations and suggests that the LCP should be replaced in between 6-12 months time. We could bench mark the service we can offer in the community now against the new recommendations. We could also use the 2012 annual "End of Life" report which showcases areas of excellent practice and finally look again at the tools and training materials on the Gold Standards Framework website. That should offer assurance about what we can offer, highlight what we might need to do differently or indeed commission.

8. How can we bring more services closer to Torrington and how will that form part of the evaluation of the pilot?

1. First we need to understand the uptake of hospital services by the people of Torrington and its Parishes. This can be done by using the secondary care data and looking for anyone attending services with an EX38 postcode as a proxy. These services will include A&E / MIU (minor injuries units), Outpatients, Day Cases and Inpatient (both Elective and Non-Elective) and diagnostics.

   Action Kerry Burton

2. This information should then be cross referenced to the Joint Strategic Needs Assessment, to ensure the population need is mirrored by the activity delivered above.

3. As part of the engagement of the public, the task group must make it their business to ask <u>what</u> the public think Torrington needs to have delivered locally in terms of services.

   For example; ideas already include: -
   - Input from a Geriatrician
   - Specialist services
   - Possibility of more diagnostics in the community and "observation day beds", complemented with an increase in planned day activity that requires nurse monitoring.

4. There is a further question about <u>how</u> those services are delivered.

   For example, ideas already include: -
   - A single point of telephone contact for all Torrington health and social care services
   - The possibility of engaging with the First Responders

- Provision for medical cover during school play times and access to the GP practices
- The use of telemedicine

9. Using the learning from towncouncil@lineone.net or Telephone 01805 626135

The Town Council are keen to hear from anyone in Torrington and its surrounds when the delivery of health and/or social care gives rise to concern. NDHT and Northern Locality would like to support this and are keen to learn from any feedback in a bid to get the model of service delivery right.

- A system of feedback and communication needs to be established, so that any concerns raised can be addressed by the appropriate part of the health and social care system for each person raising an issue.

- There needs to be an internal system allowing learning to be shared within the health and social care teams

- The Town Council will need anonymised assurance that action has been taken

- The communication team might wish to consider how services change in response to issues being raised to offer confidence that this pilot is responsive to local need and feedback.

Glossary	
A+E	Accident and Emergency Department. It is sometime referred to as ED, (Emergency Department)
Admission	In the context of this paper we are referring to an admission as an overnight stay/s to the Acute Hospital, which would be Northern Devon District Hospital (NDDH) or Royal Exeter and Devon (R,D+E) Note that NDHT stands for Northern Devon Healthcare Trust and includes all the community services and the community hospitals. NDDH is just the abbreviation for the main hospital in Barnstaple
Admissions, Deaths and Discharge report	This is a report generated every 24 hours using data from NDHT. It is known as the ADD report and is sent to each practice daily so the GPs can see which of their patients have been admitted to hospital in the last 24 hours, who has been discharged and who has deceased. We are improving the report so in time it will also tell us who went to A+E, but then came home the same day and were not admitted.
Care Package	In terms of social care this would refer to home care support, or placement in a care home. It can also include on going nursing or therapy input, to meet a service users needs once they leave hospital. Some times this package is needed on a long term basis, sometimes it will only be required in the shorter term to help a service user recover and regain their independence. More and more social services home care packages also include a rehabilitation element. You will hear that called “re-ablement” It is exactly what is says and people receive their home care in such a way to encourage them to recover their skills

	themselves through encouragement and support.
Community Bed	All community hospitals have developed in different ways, but there are two key features that are common to them all. One is that a community hospital bed has 24/7 nursing care, unlike an acute hospital bed which has 24/7 medical care amongst may other things as well. This means that it is only safe to send some one to a community bed, either in a community hospital or their own home, if their medical condition is "stable" By this we mean that we have diagnosed what is medically the matter, commenced a care plan that is seen to be working and there is not a likelihood of a rapid change or deterioration that would require urgent medical attention and more diagnostic tests.
Diagnosis on Discharge	When we are looking at the hospital data, it is important to know that when someone presents at A+E, and are admitted in to the acute hospital, there is a "reason for admission" recorded. After diagnostic tests and the person is discharged, a "Diagnosis on discharge" is recorded. This is not always the same as the apparent reason for admission, particularly with regard to the elderly frail. It is important because it is the diagnosis on discharge that tells us whether an admission was appropriate and/or whether we could have managed that person safely in the community.
Diagnostics	We use Diagnostics as a rather generic term for many and varied services and tests that are designed to tell us what is medically wrong and also when treatment is starting to work. The range of technical skills and expertise required and the complexity and sensitivity of some of the equipment it vast.
Elective/Non-Elective	Elective activity is a term used for any procedure (operation) that is planned and booked in ahead of time. Non-elective (which we sometimes call unscheduled care) is emergency work that is done straight away and hadn't been anticipated.
End of Life Care	The Department of Health (DH) have a strategy and large programme of work to support people at the end of their lives. End of life care is delivered across all services, from more generalist staff, through to specialist and hospices.
Enhanced community services	These are services based and delivered in the community, but require more specialist skills and competencies. As technology improves, it is beginning to become more and more possible to safely bring services out of the acute hospitals and closer to people's homes.
Episode of Care	This refers to a period of time where a service user receives a package of care and rehabilitation that is expected to come to a natural end, when the aims of the care and rehab. have been met.
Gold standards Framework (GFS)	The GSF relates to people who are thought to be in their final year of life. It allows these patients to be flagged on GP information systems so community teams can see who their most vulnerable patients might be. The GFS website also specialises in offering training for our generalist staff to look after these patients with skill and knowledge.
Joint Strategic Needs Assessment (JSNA)	This is a public health generated report. Public health services are interested in understanding the profile of localities that would tell us about the health and wellbeing of local communities. These "Assessments" are refreshed annually and for example for Torrington it will tell you the top disease groups for your community. It helps public bodies plan what services are required now and in the future.
Length of stay (LoS)	This is a simple measure of how many days someone has spent in hospital during an episode of care. However, a LoS is directly affected by two variables. One is the

	reason for the admission ie how poorly they are, the other is whether they are able to return home. As a value LoS, Acuity (ie how ill they are) and ability to return home need to be considered together to give any meaning to LoS as a stand alone currency
Liverpool Care Pathway	This pathway describes the steps that health and care providers should follow when a person is considered to be dying.
MIU	Minor Injuries Unit.
Step down	This is sometimes referred to as “supported discharge.” It means that someone is medically stable enough to no longer need acute care and so can leave an acute hospital, but still have care, rehabilitation or recuperative needs that require attention.
Step up	This is sometimes know as “admission avoidance” or “prevention of un necessary admission” It means that someone might have care or rehabilitation needs, but these can be safely met in their own home or a non acute bed.

KMB 17.07.13