HEALTHY PEOPLE
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Northern Devon

Northern Devon Healthcare NHS
NHS Trust
Incorporating community services in Exeter, East and Mid Devon

JOINT BOARD PAPER

Presentation of final reports of the model of home-based care and engagement and involvement activities during the Torrington Community Cares Test of Change

Executive summary

The "Torrington Community Cares" Test of Change (ToC) commenced on the 3rd July 2013 and concluded on the 31st March 2014. It involved temporarily suspending the Torrington community hospital beds on 1 October 2013 and delivering an enhanced model of community care to people in their own homes. It also included the development of options for other additional clinic services to be delivered locally in Torrington. (It was agreed after concerns were expressed by the Torrington community and following discussions with Geoffrey Cox MP that the beds would remain open as a safety net for the first 8 weeks of the ToC)

The evaluation data available at the end of the four month period showed that the model of community care was safe *(see Appendix 6, pages 5-6)* and preliminary evaluation and engagement reports were presented to Devon Health and Wellbeing scrutiny on the 16th June; and received with no restriction by the scrutiny committee.

The two organisations (NEW Devon CCG and Northern Devon Healthcare Trust) have worked closely together on all aspects of this process and now wish to jointly recommend to proceed with the permanent closure of the inpatient beds, the adoption of the community based model of care and the transfer and development of additional clinical services delivered from the Torrington Hospital building to serve the town and its Parishes.

This paper details the case for change and the supporting evidence to demonstrate that the NHS has addressed its statutory and community duties and responsibilities as part of this process evidence *(within Appendix 6, "6 Month Evaluation Report: A Summary").*

This paper is supported by the following documents:

- Full and Summary evaluation document
- Full and Summary engagement and involvement reports

Background

The management of the Torrington inpatient facilities has long been a challenge to sustain, with issues of staff retention coupled with the case mix needs. In 2010 the regional South West Strategic Health Authority supported the ring fencing of funding to trial a different model of community provision and this was taken as an opportunity to try to resolve some of these longstanding issues. This was the start of the process that led to the test of change.

The test of change impacted positively in two areas; one that was be evident to patients, the other more focussed on organisations. There was an agreed increase in community based staffing - more therapy staff, both qualified and support staff, were available, an extension to the hours of community nursing into the evenings, and the use of other services funded through S256 (NHS and Local Authority funding pool).

There were also operational and process changes in terms of referral pathways, which enabled triage, better co-ordination of care, prevention of admission and earlier supported discharge home.

As a consequence, admissions to Torrington community hospital were decreasing year on year which made the inpatient service vulnerable to sustainability and patient safety risks.

Evidence supporting the proposed change.

During the ‘Test of Change ‘(ToC), it has been essential to collect evidence to demonstrate that the revised model of care meets needs, provides safe and good quality clinical care, is sustainable, financially viable, and is received well by patients, carers and staff. It also considers an evaluation of the impact on other parts of health and social care systems to cope with unintended consequences elsewhere.

The Evaluation Framework (Appendix 1) was created in conjunction with the local community to address the concerns that they expressed and make transparent how these would be addressed as part of the Engagement and Evaluation process.

It also describes a clear line of sight between the National Health and Social Care Outcomes Frameworks, and the detail to be captured across the health economy to demonstrate the impact of the community model of care *(see Appendix 1, pages 3-4).*

An Oversight group was also established during the first phase of the ToC. The membership represented all the key stakeholders. Appendix 2 outlines the Terms of Reference and membership.

Two documents were produced for the ToC:

1. The Engagement and Involvement Report (the activities we carried out in order to involve the community in the project) – Appendix 3 (full), Appendix 4 (summary).

2. The Clinical Impact Evaluation (the clinical evidence of the ToC) Appendix 5 (full) Appendix 6 (summary).

Engagement and Involvement

Throughout the process the NHS had a desire to work in partnership with the community to develop services that could meet the needs, wants and aspirations of the Torrington Community and its surrounding parishes.

Engagement and involvement with the community started in July 2013 with briefings for key community leaders.

We heard and incorporated the anxieties about the Test of Change into the evaluation data sources and our approach. Details about how our engagement informed the progression of the Test of Change can be found in the full engagement report, however most significant was the decision to 'pause' the Test of Change and re-start on 1 October with six inpatient beds reopened for eight weeks as a safety net.

The engagement approach we took was mapped against NHS England's requirements and standards for robust patient engagement (Page 5 appendix 3).

To ensure we could hear many different voices, including STITCH (Save The Irreplaceable Torrington Community Hospital – the local action group), many different ways of engagement and involvement occurred. The full engagement report (Appendix 3) describes the various events and opportunities that were taken for engagement.

Key to this work was the voice of the patients who were receiving home-based care. 10 patient stories were carried out *(*Please see Appendix 5 of the attached Engagement and Involvement Report, which forms Appendix 3 of this document*),* three of which were developed into a film which can be seen on our specially convened website: http://torringtoncares.co.uk/patients-say/feel-receive-care-home-torrington/

We were proud of the engagement opportunities that supported this ToC. We were always flexible and responsive in our approach, continually developing activities based on feedback; indeed we received very positive feedback from the public about their experiences of these opportunities *(Please see Appendix 6 of the attached Engagement and Involvement Report, which forms Appendix 3 of this document).* We also developed very good relationships with local groups and stakeholders including The Crier, Rotary and Care Forum; these relationships helped us to communicate messages widely and effectively and offered another platform for feedback.

The six month engagement report is complete and can be found as Appendix 3. The Summary is to be found as Appendix 4.

Evaluation of clinical impact

The six month Evaluation Report is complete (pending social care data) and can be found as Appendix 5, including the summary document, Appendix 6. This report is positive and the model of care tested in Torrington between 1st October 2013 and 31st March 2014 has shown to be:

1. As good or better quality in terms of health and social outcomes than the service delivered from 10 community beds *(See Appendix 6, pages 4-7).*
2. Is clinically safe *(See Appendix 6, pages 5-6).*
3. Demonstrates no negative impact on the local health or social care system of Torrington and its Parishes nor further afield in North Devon *(See Appendix 6, pages 4-7).*
4. More productive in terms of the community services available *(See Appendix 6, page 8).*
5. Reduces "exposure to risk" in hospital and creates less institutionalisation of elderly patients. (DCC correlate this with the decrease in residential placements they are experiencing, pending data, but confirmed verbally) *(See Appendix 6, pages 1, 5-6).*

A patient experience report including the Friends and Family Test is included in the Engagement and Involvement Report *(Please see Appendix 6 of the attached Engagement and Involvement Report, which forms Appendix 3 of this document).*

The recommendations from the Oversight Group are being formulated in a meeting scheduled for the 15th July 2014 and will be tabled at the Board meeting.

The Devon Health and Wellbeing Scrutiny Board received the Summary Evaluation and Engagement Reports on the 16th June 2014, requesting support for this change. Their advice was that there is no restriction from scrutiny that would prevent the CCG and North Devon Healthcare Trust proceeding and that they would wish an update in 6-12 months. The minutes from this meeting are in the public domain already and a podcast is available under Item 4 at http://www.devoncc.public-i.tv/core/portal/webcast_interactive/118309).

Financial Viability and Sustainability

This model of care is shown to be more cost effective in terms of the direct comparison to the cost of beds**.** The headline summary is below but more detailed breakdown and analysis is embedded within the Clinical Impact Evaluation *(Appendices 5 – pages 26-27 and 6 – pages 8-10).*

	Torrington
	£000
Total Inpatient Direct Costs Saved	-549
Additional Community Funding	383
Savings from Reduction in Emergency Admissions	-80
Net savings per annum	-246

Public Duties and Responsibilities of the NHS

The Executives and Boards of Northern Devon Healthcare Trust and the Northern Locality of NEW Devon Clinical Commissioning Group are required to be assured that the recommendations and outcomes of the test of change adhere to the “Four Tests” described by NHS England in Planning and delivering service changes for patients.

In 2010 the Department of Health first set out four tests for major change, placing an expectation on commissioners to assure themselves that any proposals take into account certain factors. These tests continue to be reinforced:

1. Support from GP commissioners
2. Clarity on clinical evidence base
3. Strengthened patient and public engagement
4. Consistency with current and prospective patient choice

It is the responsibility of the commissioner to lead service design and change, ensuring alignment with commissioning intentions. As member organisations, CCGs are responsible for assuring themselves that proposed changes have the support of their member practices.

It is the responsibility of the provider to deliver evidence based, quality care that is safe and sustainable. The provider needs to assure itself that people impacted by a change in service provision are involved in the process of change and that their feedback is listened to and acted upon. This includes service users and staff.

The Northern Devon Healthcare Trust Board also needs to be satisfied that the model of care delivery represents significant and lasting improvements for the benefit of patients and needs to be assure that the “Four Tests” have been rigorously applied.

Support from GP Commissioners

The Northern Locality Board members of the CCG have been involved from the outset in the Test of Change and will need to be assured that the model proposed meets the needs of patients in terms of safety and quality.

It is recognised that support from all member practices is not unanimous, but acknowledges that this is a difficult conversation for individuals who are also members serving the affected communities. Local Torrington GP’s and practice staff have been involved in several of the evaluation exercises, including detailed case reviews to understand patient needs.

Opportunities have been taken by the Northern Locality GP commissioners to share the rationale and findings widely through a range of GP forums, and practice meetings *(see pages 14-15 of the Engagement and Involvement Report in Appendix 3 of this report).*

The practices in the Northern Locality have been actively involved in improving and expanding community based care options and initiatives such as the 'virtual ward ' and Gold Standards Framework for end of life care have been positively supported.

The changed model and closure of beds has already been debated in the private part of the northern locality board on several occasions; this board will vote on the recommendations on the 23rd July and will thus demonstrate their support formally at this point to the proposal if agreed.

Care of the Elderly consultants for Northern Devon Healthcare Trust have been integral to, and supportive of the developments. It is recognised that care for older people, which this change largely affects, is more complex as people live longer with more complex co-morbidities. This type of development is only possible with active involvement and support from both primary and secondary care clinicians. In Torrington this has been possible, with our secondary care consultants being advocates for the changes.

Clarity on Clinical Evidence Base

There has been a national drive to move services out of acute hospitals and in to the community since 1990. Public Health has conducted a review of evidence. *(Appendix 7*, *pages 8-9).* Their summary is:

''There is good evidence that hospital at home care is at least as safe and effective as care in a hospital setting, as long as patients are carefully selected. The evidence outlined in this paper is relevant to older adults across a range of conditions."

"*There is robust evidence from three Cochrane Systematic reviews, and other supporting sources, that hospital at home patients have similar or reduced levels of mortality, similar levels of readmissions and fewer patients being in residential care at follow up than in-patient care. Hospital at home also significantly increased patient satisfaction."*

The full report can be found on www.torringtoncares.co.uk

Strengthened Patient and Public Engagement

A full summary of the patient and public involvement is described in Appendix 3 and summarised in Appendix 4.

There have been two diametrically opposed views, with a nucleus of dissention focussed in Great Torrington itself about the health care requirement for Torrington. The most vocal objection has centred on the potential loss of beds and therefore opposition to the new model of community service delivery *(see Appendix 3, pages 26-29 for more information on how we used the concerns raised to inform our approach).*

The patients and carers who have experienced the service value it, evidenced through the Friends and Family Test scores (which was used to assess patient experience) of +75. The equivalent was not available to compare previously as the model was bed based, not community based *(see Appendix 5, pages 24-25).*

Although we heard considerable objection to the loss of the beds, the Torrington community also voiced and recognised the significant benefit to the wider community of developing a community health hub out of which other services could be provided. Indeed all services that were developed were in accordance with the community feedback and there was most need for.

The CCG understands and appreciates the strength of feeling, and has listened to all views expressed, but the NHS does need to make difficult and often unpalatable decisions based on clinical safety, quality, sustainability of care models and affordability.

To try to understand and address the views expressed by the public, an additional action plan was compiled from the public engagement activities of others including Healthwatch, “Save the Irreplaceable Torrington Community Hospital” (STITCH) action group, Devon Senior Voice and the Drop in sessions conducted by Torrington Town Council.

In analysing the content of the engagement activities it became apparent that there was an expressed desire for beds, but the usage of those beds was described by some respondents as convalescence, respite and end of life care *(see Appendix 3, page 24).*

Neither convalescence nor respite requires the clinical services of medical staff; end of life may, but the research evidence shows that people would rather be cared for at home. The remainder of the responses gave no reason for the requirement for a bed and none gave an explicit medical reason.

The engagement processes undertaken led the CCG to commission some amendments to the **model and design of the project** in response to important comments from the public and clinical teams. These included the following:

- A key criticism was the difficulty in accessing the teams for the public and other clinicians; to overcome this, a single point of contact was created with good effect. This required some additional administration time and all patients are now provided with a business card with key contact numbers.

- Comments were made about the need to more effectively co-ordinate clinical care for people being discharged from hospital and set up the discharge plan. An additional band 6 nurse was appointed and this again has proved helpful, and an important function in making sure planning for discharge is safe and effective.

- There was a desire to increase the number of options for clinics to be made available locally. This was taken on board and Northern Devon Healthcare Trust has actively moved clinics and services from NDDH to the Torrington Hospital site.

  To do this, a band 6 day-centre nurse was employed part time but this has now increased to full time. The range of clinics and services have increased significantly and are a mix of repatriated clinics from the main hospital sites in Barnstaple, as well as additional support from primary care in the management of patient care.

  Examples include ultrasound clinics, day treatments, such as wound dressings, drug treatments including chemotherapy, IV drugs, midwifery drop in, family planning and sexual health, anxiety and depression services, allergy services (starting shortly).

- The group identified in the Equality Impact Assessment and in conversations with the public were carers and issues relating to their support. It was the acknowledged that there could be an unintended impact on the carer and family and concern that pressure may increase. This was picked up by the commissioners and work has been completed mapping all local support for carers, to make sure the services are

better known, and priorities for joint working with the county council is being formulated.

Approaches such as focus groups, Tour and Talk, public meetings and our methods of communication were all introduced and/or informed by the feedback gained through our engagement and involvement activities.

Consistency with Current and Prospective Patient Choice

The NHS England guidance is clear that the concept of patient choice relates to the choice of provider once a clinical decision is made about need.

The Torrington community's challenge to the Northern Locality and NDHT has been that they should have a "choice" to be admitted to a community hospital bed, or not. This is not commensurate with the NHS guidance, in that, whilst the public are encouraged to take an active part in their care with medical staff, they do not have admitting rights to hospital beds, which is based on need defined by clinicians.

It has been noted that the new model of care, increases choice, in its more general sense, for more people. Patients can still be admitted to a bed, but now there is an option to be cared for at home, return home sooner, spend less time in a hospital bed or not even be admitted into hospital in the first place (where this is clinically safe).

Torrington hospital had 10 beds which, on average, were used by 90 people per annum. The changed model of care enabled more people (180-200 on case load at any one time) to be cared for in their own home *(see Appendix 6, page 8)* which indicates that in terms of use of NHS resources more people benefited from the community based model. This model of care is also scaleable by increasing community staff numbers should demand increase whereas the hospital would never be able to provide more than 10 inpatient beds.

The number of patients on the community caseload only increased by 11, (from 449 – 460, see Appendix 5, page 23) but the number of admissions avoided was 97. This tells us that we know who our vulnerable patients are and by increasing the number of visits, and getting to them sooner, we can keep them at home. We also know that people would prefer to be cared for at home, when it is clinically safe to do so. (See appendix 7).

Responsibilities of the CCG under the NHS Act (2006), and subsequently 2012 and 2013

Section 242 of the NHS Act 2006 states that:

"Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services are, whether directly or through representatives, involved (whether by being consulted or provided with information, or in other ways) in:

a) The planning of the provision of those services
b) The development and consideration of proposals for changes in the way those services are provided, and
c) Decisions to be made by that body affecting the operation of those services.

The duty applies if implementation of the proposal, or a decision (if made), would have impact on:-

a) The manner in which the services are delivered to users of those services, or
b) The range of health services available to those users.

(Whilst we quote the 2006 act, in 2012 and 2013 there was a strengthening of national policy to ensure the NHS fulfilled its duty to engage and involve people in the future direction of its services. The Health and Social Care Act in 2012 and the NHS Constitution 2013 states that patients and the public have a right to be involved in the planning of healthcare services, and that information and support will be provided in order to do this).

The NHS therefore has a legal obligation to consult when proposing changes to the way local services are provided, operated or developed in two ways; they are:

- The duty to consult and involve patients and the public in an on-going way, not just when major changes are proposed.
- A duty to consult with Local Authority Overview and Scrutiny Committees on proposals for substantial changes

Our responsibilities in this area encouraged us to become more actively involved in discussion with the public much earlier than was formerly the case. . This was also acknowledged in the feedback from the Devon Health and Wellbeing Board. Lessons were learnt from this change and it is hoped that the level of information provided in the engagement report demonstrates a difficult start but a real drive to have meaningful engagement with the public. A copy of the Equality Impact Assessment is shared as Appendix 8.

Responsibilities of the CCG under the Equality Duty Act 2010

The equality duty relates to how we commission for the protected characteristics of:

1. age
2. disability
3. gender reassignment
4. pregnancy and maternity
5. race – this includes ethnic or national origins, colour or nationality
6. religion or belief – this includes lack of belief
7. sex
8. sexual orientation

The Public Sector Equality Duty (2011) has three main aims. It requires public bodies to have ***due regard*** to the need to:

9. **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
10. **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
11. **foster good relations** between people who share a protected characteristic and people who do not share it.

The Equality Impact Assessment produced for the CCG is attached as Appendix 8.

This identified that there could be a small number of patients who might need to receive community hospital care in a community hospital bed other than Torrington, but the number would be very small in comparison to those who would be better served by

being cared for at home and those who would receive clinical services in Torrington and not have to travel to Barnstaple *(see Appendix 8, page 7).*

Recommendations

On the 22nd of July the Northern Devon Healthcare Trust will be considering the following recommendations at the Board Meeting:

1. The Northern Devon Healthcare Trust Board is asked to provide community services to the people of Torrington using the enhanced model of care, in place of the beds in Torrington community hospital, which will be closed.

2. The Northern Devon Healthcare Trust Board is asked to support the change in use of the Torrington Community Hospital building and continue to work in collaboration with the Commissioner to maximise the cost effective potential of delivering additional services for Torrington and its parishes from the hospital site.

At the Board meeting of the Northern locality members are requested:

1. **The Northern Locality Board of the CCG is asked to recommend the de-commissioning of the Torrington community hospital beds and support the re-provision of community services by commissioning the enhanced model of care.**

2. **The Northern Locality Board of the CCG is asked to support the change in use of the Torrington Community Hospital building and continue to work in collaboration with the Provider to maximise the cost effective potential of delivering additional services for Torrington and its parishes from the hospital site.**

Next steps

If Northern Devon Healthcare Trust and the Northern Locality of NEW Devon CCG both recommend the change in clinical model the plan will be to permanently close the beds.

The Governing Body has received a paper on the 17th July 2014 informing them of the recommended options for the locality board to decide in July 2014, and the outcome will be recorded in the Governing Body minutes of the September 2014 meeting.

Appendices

1. Evaluation framework
2. Terms of reference for the oversight group
3. Six month engagement full report
4. Six month engagement summary report
5. Six month clinical impact evaluation – full report
6. Six month clinical impact evaluation – summary report
7. Public Health review of clinical evidence of the effectiveness of home based care.
8. Equality impact assessment
~~8.~~9. Appendicecs for Engagement Report