HEALTHY PEOPLE
living healthy lives
in healthy communities
Northern Devon

Version 6 / Oversight

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

Appendix 6. Clinical Board 23.07.14

6 Month Evaluation Report
A Summary

Prepared for the Health and Wellbeing Scrutiny Committee, 16th June 2014

The model of community care, tested in Torrington between 1st October 2013 and 31st March 2014 has shown to be:

- As good or better quality in terms of health and social outcomes than before
- Safe
- In receipt of excellent feedback from patients through the Friends and Family Test
- Demonstrates no negative impact on the local health or social care system of Torrington and its Parishes nor further afield in North Devon.
- More cost effective in terms of the direct comparison to the cost of beds
- More productive in terms of the community service available
- Reduces "exposure to risk" in hospital and creates less institutionalisation of elderly patients.

Financial picture:	Torrington £000
Total Inpatient Direct Costs Saved	-549
Additional Community Funding	383
Savings from Reduction in Emergency Admissions	-80
Net Savings	-246

We would like to recommend this model of health and social care to you and draw your attention to this brief video that sets the scene and direction for health and social care services in the future.

Please find Sam's Story on the King's Fund website available at http://www.kingsfund.org.uk/audio-video/joined-care-sams-story

Introduction

1. The Enhanced Model of Health and Social Care.

2. Clinical and Financial assurance, and listening to the community.

3. Additional services to better serve the wider community.

1.1 The Enhanced Model of Health and Social Care: The story so far

Ten years ago there were very few community services in Torrington; very limited therapies and skeleton nursing staff working 5 days a week. GPs were working hard but had just two options for patients who were unwell: one was to admit them into the Acute Hospital and the other was to refer them into the Community Hospital.

A decade later (2010), an inspirational GP wrote a business plan. He suggested boldly and in line with clinical evidence that there was no need for so many people to go to hospital; they could be well looked after at home, if only there were sufficient community services.

The Strategic Health Authority endorsed the plan but added a rider. The rider was that if we could make this model work in Torrington, then they would consider funding the developments for the rest of Devon. Why Torrington? Because, it represents the rural challenge of Devon; if we could make the model work for Torrington and its Parishes, its resilience would be proven.

At the same time came funding through Section 256 (S256) which enabled community investment and implementation of the plan.

This confluence of strategy and funding meant that Devon PCT set up a programme of work and projects called “Optimising Community Services “ Local clinicians were engaged and from 2011 Torrington began to benefit from investment in health and social care staff and services.

1.2 So what is the enhanced model of care that is provided in Torrington?

Because the population is both small and rural, Torrington and its Parishes have one team of nurses, therapists and support staff delivering 3 particular functions. Our Torrington team deliver Planned care,

Step up care and Step down care.

1. Planned care is the easiest to describe; it is those tasks or procedures we know our patients need, like taking bloods or walking practice or review of medication.

2. Step up care is the rapid introduction of additional services for someone who has a temporary, urgent but clinically manageable condition such as a urine infection, which can be safely treated at home without the disruption of a hospital admission.

3. Step down care describes those services that can be put in place to allow someone to return home as soon as possible after a necessary hospital admission.

Other services became available too, such as support for hospital discharges, recuperative care and rapid response workers.

Little of this had been possible in the past, but the effect of the investment of money and this new model of care led to the improvement of community services and an unintended consequence for the Community Hospital.

1.3 What happened to the hospital?

The impact of the new community team was twofold:-

I. Keeping people in their own homes when it was safe to do so using the Step up model of care meant that a community hospital admission was no longer necessary.

II. The community team were supporting people to come back to their own homes sooner than previously as part of their Step down function and therefore bypassing the community hospital altogether.

This impact was positive for patients. Evidence shows that hospital admissions increase the likelihood of Falls, MRSA, C.Dificile and institutionalisation; there is also evidence to suggest that being cared for at home reduces your chances of being admitted to a care home and improves your chance of living longer. Staying at home, or getting back home as soon as safely possible is good for patients.

However, as a result, the small 10 bedded hospital with a 67% occupancy rate declining at 15% per annum was bound to find its function and viability called in to question. With fewer patients, more and more of whom were in hospital for social reasons not health needs, it became increasingly difficult for existing staff to maintain their clinical competencies.

2. Clinical and financial assurance, and listening to the community

The Health and Social Care Act 2012 mandates the NHS to work closely with the public to form plans for the development of services. As such In October 2013, a document called “Meeting Local Needs” was launched in Torrington.

The hypothesis that was set out in the document was that given it was highly likely that the community team could care for the majority of patients from Torrington and its Parishes at home, there would be a wider community benefit in redirecting health resources into providing a range of clinics and other services from the hospital instead of providing a limited number of beds.

These services would be closer to home than before, more convenient and more diverse, and designed for children and families not just meeting the needs of the elderly. If the hypothesis about home based care proved to be right, the question then became “What should the role of Torrington Community Hospital be in the future for the greatest benefit of people in and around Torrington?” That was the question posed by Meeting Local Needs.

The community response is detailed in the Summary to the Engagement Report, but for the purposes of understanding the impact on the Evaluation, there were five key themes from the public.

- One was that the public interpretation was that their hospital was being closed and they felt it was their right to adjudicate on the question of whether there should be hospital beds or no hospital beds.
- The second was that there was significant confusion between the model of short term enhanced home based care we were trying to explain and long term, social care provision.
- Although the public did want extra clinics, they also wanted the continuing availability of hospital beds.
- The, “beds” were synonymous with ”safety”; how could a model of care as apparently invisible as this community model be safe?
- So all in all, conversations gravitated around bed provision and enhanced based community care, making it very difficult to maintain a dialogue about the provision of a Hub for the delivery of health and social care clinics and other services

2.1 The evaluation framework

The evaluation framework was developed to address the first four issues above and provide assurance for the public and ourselves that the model of community care was:

a) Safe
b) of as good or better Quality than the services provided before, and

c) Sustainable.

An Oversight group was established with stakeholders to monitor the evaluation process. The draft 4 month evaluation data is available on the Torrington Community Cares website

2.2 Safety

First and foremost, any change to health services in Torrington needed to be safe. The following questions set out evaluation findings to the pertinent safety questions.

2.2.1 Are patients at greater clinical risk as a result of home based care?

No.

Here are the tests we applied:-

Test	Data based answer
Was there an increase in Accident and Emergency (A&E) attendances?	**No.** There was an increase of 3% over the 6 month period but this is in line with an overall 3% increase for the Northern Locality. The model of care did not therefore impact on A+E attendances.
Was there an increase in emergency admissions to the district hospital?	**No**, in fact bucking the local trend there has been a decrease, -10%
Was there an increase in attendances at the neighbouring minor injury services?	**No,** in fact there has been a drop in attendances by -12%
Were more Torrington residents being admitted to other community hospitals?	**No,** in fact there is a decrease of - 56% in total
Was there an increase in telephone calls to the “Out of Hours” (OOH) services?	**No,** there was a decrease of -5%
Was there an increase in the calls to the ambulance service?	**Yes,** There was an increase in Torrington, but that was in line with the increase across the Northern Locality as a whole.
Was there an increased length of hospital stay at NDDH?	**Yes and No.** Over the 6 month period a small percentage of Torrington patients stayed on average 1.5 days longer in NDDH before going home. While this represents an increased length of stay at the Acute hospital, in the past these same patients would have gone to the community hospital adding an additional 28 –

	30 days to their overall length of hospital stay. This also represents one less transfer of care and a quality benefit for elderly and frail patients in unfamiliar surroundings.
Were Torrington patients returning home more likely to be readmitted to NDHT within 30 days?	**No.** readmission rates showed no significant change (+3%).

2.3 Quality

The Quality of services is essential. To test the quality of services we asked patients, carers and staff.

2.3.1 Are patients and carers happy with the service they have received?

Yes.

- The National Friends and Family test has been offered to every person who has received the enhanced service: NDHT aspire to achieve +60, the Torrington Enhanced Care service achieved +75.
- To capture opinions of patients and the public, we interviewed willing patients to understand their views.

"I have no complaints whatsoever. They are all very competent and patient and I never feel rushed, they just stay for as long as it takes. The whole thing is really very organised. They are all very dedicated, we are lucky to have people like them!"

A carer said - "What is wrong with X is one of the most terrible things you can have wrong with you, but knowing there are people around you that you can rely on makes it easier"

"When you've got what I have got it is just terribly scary – it really helps just being able to talk things through. I've never come across a group of people that tend to us so well. It is really comforting. The nurses come in whenever we need them, we just have to ring".

"I have to say that nationally the care profession do not get the best kind of treatment so far as Torrington and the NHS in Torrington is concerned. From my experience the people I have been concerned with have been remarkable. I didn't appreciate it at all the care I could have at home".

Patient stories are shared in the Engagement document and this link http://torringtoncares.co.uk/patients-say/feel-receive-care-home-torrington/ takes you to a film of patients who received the enhanced care and

are happy to share their experiences.

2.3.2 Have end of life (EOL) patients been adversely affected?

No.

This group of patients were chosen because the public expressed the greatest concern about their care needs being met and they were taken as a proxy for some of the most complex to care for outside a hospital setting.

End of life patients received:

- An increase of more than double the number of visits as part of the enhanced model of care.
- An increase in the length of each visit by approximately 20%.

2.3.3 What are our staff telling us?

Torrington community staff are describing an increase in satisfaction in their jobs through the ability to deliver high quality care. The nursing team hours have been extended to 8am-8pm and this extra time has allowed for a greater range of more complex treatments to be offered and more time to be spent with patients when they need it.

The community staff have worked with managers to create and develop this model of care. They have enhanced their clinical skills, developed additional capabilities and have real belief and enthusiasm in what they are doing.

Of course they are sad to think of the possibility of losing the beds, and the nature of the protest to keep them has been challenging to work with alongside delivering care. Here is an example of their work.

Mr X was discharged from hospital within a few hours of receiving the news that his condition was no longer responsive to treatment. It was his wish and that of his family that he should return to his home.

The district nurse team received a request to undertake an urgent assessment of his needs that day to enable him to be cared for to a high standard at home. Initial assessment was undertaken to identify his physical, psychological and social needs.

Mr X had complex physical needs due to being bed bound. He required continuous oxygen due to breathlessness and needed medication administered via a syringe driver to control pain and other physical symptoms caused by his condition.

Equipment was ordered including a hospital bed, a pressure relieving mattress and manual handling aids. This was all in place within 24 hours of discharge from hospital.

Nursing interventions were put in place to manage loss of bodily functions, thus maintaining dignity and preventing further problems.

The District nurse team were assisted by the hospice to home, Macmillan nurses and out of hours nursing teams to provide 24 hour support both physically and emotionally.

Mr X was able to stay at home with his family as a result of these interventions.

2.4 Sustainability

The key question is whether this model of care, accepted as being safe and as good if not better quality, is affordable and sustainable? Or in other words, what is the financial net effect of closing the beds and investing in community services?

2.4.1 Has the community team delivered the enhanced service ?

Yes.

(The baseline data used below was for the same period 2011/12)

- The total number of visits increased by 37%
- The total number of patients seen increased by 2%
- The number of patients receiving an urgent response increased by 20%
- The length of visit increased on average by 22%
- The number of patients receiving daily visits increased by 16.7%
- The number of people receieving more than one visit per day increased by 150%

2.5 What are the financial implications of this model: Is it sustainable and workable for the future? - Financial schedule

There has been challenge that the “Torrington Test of Change” model of care will be more expensive than retaining the ten beds in Torrington hospital.

Below is a cost breakdown for the Torrington Hospital. It is important to note a number of issues:

- The staff costs for Torrington Hospital are calculated on the basis of the rota required to staff 10 beds.
- The overall cost of the hospital is the same, irrespective of bed occupancy.
- Average number of beds utilised at any one time in 2012/13 was in fact 6.7 rather than 10.

Torrington Community Hospital Costs

	£000
Medical Staff	30
Inpatient Beds	519
Total Inpatient Direct Costs	**549**
Admin & Building costs (utilities, rates & maintenance)	177
Therapy support (from community services) & other patient services (pathology, radiology)	67
Total services including building costs	793
General Corporate Overhead Allocation @ 20%	158
Total Including central overheads	951

The direct cost of running this 10 bedded unit as described above (i.e. minimum cost) for the health economy is £549k per annum.

Torrington Community Services Costs

	£000
Original Community Nursing and Therapy	504
Additional Community Funding	383
Total Community Funding	887

This is the cost of the total Nursing and Therapy services needed to support the new model of care in the community setting

The cost of running the community services prior to the enhancement of the service in 2011 was £504k per year. With subsequent investment, the cost of the Enhanced Community Services is £887k per year showing an increase of £383k per year.

In other words with the building retained, the health economy would save £549k per year on bed costs and incur an extra cost of £383k per year in the community, making a net saving of £166k per year.

Additional savings can be identified from the reduction in emergency admissions as a result of the investment in community services. Comparison with the baseline period in 2011/12 showed a reduction in emergency admissions of 74 people. This equates to a saving of £80k per annum based on the average general medicine tariff at a marginal rate of 30%. At full tariff the saving would be £266k.

	Torrington £000
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Additional Community Funding	383
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Net Savings	-246

2.5.1 Summary of finance and sustainability

Taking into account activity and the financial schedule, is this model sustainable?

Yes, this model is affordable, but in the context described below:

1. This model does require additional investment in to community services
2. This model does release some cash.
3. The model's efficiency is in the ability to offer a wider range of services more locally to more patients
4. Its increased flexibility is to be able to offer enhanced care to people depending on their needs, rather than being restricted to bed capacity.
5. Its potential is that it can make best use of the added benefits of integrated care in the community between statutory organisations.
6. Its strength is that packages of care can be bespoke every time and make best use of local community resources, for example the voluntary sector.
7. Its value is that each package of care can be personalised to best meet the needs of the patients and their carers and family.
8. Its sustainability lies in the job satisfaction of the workforce delivering this model of care.

2.6 Listening to the community

The evaluation framework was only one of several sources used to capture the concerns of the public. Further views were gathered through the engagement process and specifically through the Healthwatch Report, the Devon Senior Voice Questionnaire and the drop-ins arranged by Torrington Town Council They were compiled in to an action plan and addressed.

It was also noted that there was a Greater Torrington Town Poll, demonstrating a 32% turnout of voters,

supporting the Hospital beds in the Hospital.

Some themes and issues represent our failure to articulate issues clearly enough and are a result of public misunderstanding; some were specific to Torrington and others need to be addressed either across the Northern Locality as a whole, or indeed at CCG wide level. The concerns and responses will be found in Sections 9 and 10 of the Engagement Report, for example:

Theme	Issues
Safety and Risk	Torrington Hospital as a safety net / discharge support
	24/7 care / Out of Hours Care
	Living alone, meals and nutrition
	Fear and reassurance
Beds	Convalescence
	Respite
	Bed blocking
	“Just in case beds”
Carers	Lack of support
Access	Transport/Travel
	Winter and weather
	Social isolation / rurality
Quality and sufficiency; Home based Care versus social care	Time
	Expertise
Voluntary sector	

3. Views of the General Practitioners (GPs), Consultants and senior community clinical staff

The Torrington GPs have found themselves in a difficult position. The GPs are advocates for their patients and as such one Practice wanted to share the public sadness at the temporary closure of the beds. In a recent letter to the CCG there is both realism in recognising the challenge of delivering healthcare to an increasingly elderly population within a finite budget. This letter acknowledges that there is a lack of consensus amongst the GPs about the two models of care. They remain concerned about winter resilience and the security of the additional community funding.

As part of the pilot there has been a detailed examination of patients’ notes and clinical pathways, undertaken by the consultant geriatrician, GPs and matron. The outcome demonstrated

1. That there is a need for specialist community hospital beds, but numbers are small, perhaps two admissions per month
2. That the new model of care had not generated additional work for the GPs

3 The bed based model has been good, but so is the new mode, which can include bed based care, plus enhanced community care and could increasingly include expanded clinics and clinical services for Torrington and its Parishes
4 The support of the Geriatrician in overseeing the most complex cases was highly valued.
5 Patients had received the right level of care, in the right place at the right time over the period of the 6 month evaluation.

4 Additional services to better serve the wider community

National policy is clearly indicating a direction of travel towards integration of health and social care and the importance of illness prevention and keeping well. There is increasing reference to "Health and Wellbeing Hubs" as a way of describing what this might look like.

In local community discussion, there are lots of excellent ideas for the services that Torrington and its parishes could benefit from. Our emerging vision is that Health services can be brought more locally to Torrington; but running alongside them would be other services to meet social needs, possibly delivered by the voluntary sector, services for supporting carers, and for families and young people.

For example:

Some Torrington patients have to travel to Exeter to see the neurologist and then return to Exeter repeatedly to receive their on-going treatment.

Now our nurses are trained to give some of those treatments, wouldn't it be better if the consultant came to run the clinic in Torrington? Treatment could be given in the hospital and at the same time perhaps a support group for example for Parkinson's patients could be run, or there could be education for carers?

There is a clinic list available as Appendix 10.iv in the Engagement Report which already needs to be updated. It details some of the clinics running now.

Below is a brief list of just some of the additional services that would feasible to establish in Torrington, should space be available in the hospital building if there is space made available through the absence of the previous 10 beds"

Potential Clinics and Services from a Torrington Health and Wellbeing Hub	
Nurse led clinics	The existing IV clinics could extend to 5 days a week with additional clinical services such as wound management and catheter care and include a "drop in" function for known patients.

Ultra sound	Clinics to commence once weekly from 1st July for 20 people per clinic
Podiatry	An extra chair will allow nurse led nail cutting for healthy feet
Dementia care for carers	Compliment the Memory café, with carer support and education
Physiotherapy classes	Use the extended Gym to expand the number of classes (could double) and allow bookable space for other services
Continence service, flow clinic	This clinic would enhance the continence service in Torrington
Depression and Anxiety service	Mental health services want to move into Torrington Hospital to be more accessible
Voluntary Sector presence	The voluntary sector would like a presence in the hub, delivering some services on site and offering support and advice
Cafe	There is a bid to open a small café for refreshments on site
Extended library service	This would support the library service, particularly their health related information function.

5. Summary

In summary, the key messages from this test of change are:

1. The enhanced home based service is safe
2. The enhanced home based service is of as good if not better quality according to patients, staff and supported by health and social care data
3. The benefits in terms of sustainability of the home based services are clinically and financially, convincing
4. The possibilities of bringing health services into Torrington are real and can be cost effective for the patient and the health service
5. The opportunities for enhancing patient and carer experience by collaboration with the voluntary sector and the independent sector, social care and mental health services are real, viable and in line with national policy
6. The range of service users who could benefit from these developments is far greater than the patients who would have traditionally used the 10 available beds.
7. The impact on secondary care yields a cost saving.

6. Recommendations

This model of enhanced health and social care service delivery is recommended as the way forward for Torrington and its Parishes.

KMB 04.06.14