Northern, Eastern and Western Devon
Clinical Commissioning Group

The proposal to remove inpatient beds and increase community services in Torrington, North Devon.

Equality impact assessment

Introduction

The Board must be aware of the specific duty set out in section 149 of the Equality Act 2010.

> *'Meeting the general equality duty requires 'a deliberate approach and a conscious state of mind'. R (Brown) v Secretary of State for Work & Pensions [2008] EWHC 3158 (Admin).*

The Board must know and understand the legal duties in relation to the public sector equality duty and consciously apply the law to the facts when considering and reaching decisions where equality issues arise.

The public sector duty is set out at section 149 of the Equality Act 2010. It requires the PCT, when exercising its functions, to have 'due regard' to the need to eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

A 'protected characteristic' is defined in the Act as:

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race (including ethnic or national origins, colour or nationality);
- religion or belief;
- sex;
- Sexual orientation.

Marriage and civil partnership are also a protected characteristic for the purposes of the duty to eliminate discrimination.

Having due regard to the need to ‘advance equality of opportunity’ between those who share a protected characteristic and those who do not includes having due regard to the need to remove or minimise disadvantages suffered by them. Due regard must also be had to the need to take steps to meet the needs of such persons where those needs are different from persons who do not have that characteristic, and encourage those who have a protected characteristic to participate in public life.

The steps involved in meeting the needs of disabled persons include steps to take account of those persons’ disabilities.

Having due regard to ‘fostering good relations’ involves having due regard to the need to tackle prejudice and promote understanding.

Complying with the duty may involve treating some people better than others, in order to achieve an equal outcome, as far as that is allowed by discrimination law.

The equality duty arises where the CCG is deciding how to exercise its functions, including the function of the commissioning of integrated children’s services.

The CCG's duty under section 149 of the Act is to have 'due regard' to the matters set out in relation to equalities when considering and making decisions on the provision of ICS in Devon. Accordingly, due regard to the need to eliminate discrimination, advance equality, and foster good relations must form an integral part of the decision-making process. The Board must consider the effect that implementing a particular policy will have in relation to equality before making a decision.

There is no prescribed manner in which the equality duty must be exercised. The potential equality impact of closing the inpatient beds in Torrington Hospital and increasing the availability of community services has been assessed, and that assessment is found below. A careful consideration of this assessment is one of the key ways in which members can show "due regard" to the relevant matters.

The Locality Board should be aware that the duty is not to achieve the objectives set out in s.149. Rather, the duty on public authorities is to bring these important objectives relating to discrimination into consideration when carrying out its public functions. "Due regard" means the regard that is appropriate in all the particular circumstances in which the authority is carrying out its functions. There must be a proper regard for the goals set out in s.149. At the same time, the Locality Board must also pay regard to any countervailing factors, which it is proper and reasonable for them to consider. Budgetary pressures, economics and practical factors will often be important. The weight of these countervailing factors in the decision-making process is a matter for the Board in the first instance.

1. **Name of the strategy** – Change in model of community services for Torrington, North Devon
2. **Commissioning decision –** to permanently close the inpatient beds in Torrington Community Hospital and increase the availability of community based services.
3. **Locality and service areas covered:** ✓ Employees ✓ Patients/clients/service users

- ✓ Partnerships/organisations
- ✓ Staff from other organisations

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5. Introduction

The management of the Torrington inpatient facilities which contains ten beds used mainly for older people has long been a challenge to sustain, with issues of staff retention, coupled with a case mix of patients who did not necessarily need trained health professional oversight on a twenty four hour basis. In 2010 the South Western Regional 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 which led to the test of change.

The test of changes impacted in two areas one which would be evident to patients in term of the way local services were provided, 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 LA funding pool). This allowed people who would have previously been managed as inpatients to be cared for at home, where it was clinically safe to do so. Local beds in Torrington were closed but access to local care homes through spot purchasing and the use of adjacent community hospitals were available if an inpatient stay was necessary.

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.

The additional funding made available through section 256 arrangements with the local authority to develop alternative community models of care, was intended to avoid hospital admissions and care for people safely at home in greater numbers and with a greater complexity of care needs than could have previously been offered in the community. This changed model is known locally as the Test of Change (ToC) for Torrington.

The other intended impact of the 2010 business case was that by investing in community services, fewer patients would have the need to present to Accident and Emergency Services at Northern Devon District Hospital and thus fewer would be admitted to the acute hospital.

The Test of Change (ToC) in Torrington 2013/14 in terms of community investment using the above assumptions should have an impact on the health economy as a whole and should impact on “Step up” and “Step down” care.

By this it is meant that the investment in community services should impact on quality and quantity of services delivered in the community as a whole. In practice that suggests that people either do not need a hospital admission in terms of “Step up” care or receive appropriate support to enable them to remain safely at home, or “Step down care” by which we mean an earlier discharge from the Acute hospital, but with clinical support at home. The changed model of care was anticipated to impact on the local community in different ways:

- One population specifically affected by this test of change will be those who would have been traditionally admitted to the Torrington Community Hospital as “Step up” patients, who would now be cared for at home.

- The second group would be those who would previously transferred to Torrington Community Hospital (and in some instances to Holsworthy and Bideford Hospitals) from Barnstaple Hospital who can now be safely cared for at home (Step down)

- Another group of people affected will be those community patients who now can expect to receive a service delivered from Torrington Community Hospital, but whom previously would have either had to travel to receive the same service elsewhere (Barnstaple or Exeter acute hospital care

services).

- Or those who are not elderly but still have a health requirement in the community, not previously met in Torrington. This will include mental health, families and children amongst others.

6. Background

Initially the plans included the whole of the Torridge cluster. The community team within the Torridge cluster came together in 2012 to discuss the development of community services. The result of that discussion was an agreement that all areas needed an increase in availability of community nursing care and one of the early changes was the extension of nursing hours.

The agreed plan was to extend the district nursing team in Holsworthy commencing work at 8 am rather than 9 am. For Torrington the service was funded to cover 8 am – 8 p.m.

For the test of change there was agreement to concentrate more fully on Torrington, and, in addition to the nursing care increases there were also additional therapy staff employed and co-ordination functions. Operationally there were significant changes in processes for admission, discharge and general care co-ordination for Torrington and district residents.

The impact of this investment, co-created between commissioner and provider has contributed to a model of service delivery that has:

a) impacted on the usage of community hospital beds
b) opened up opportunities for more complex and intensive delivery of health care at home
c) Created an opportunity for training staff to deliver more complex treatments at home or closer to home.
d) Offered a greater range of locally provided outpatient and day case investigations and treatments.

Some headline figures are described below of the impact of the test of change;

- There were 74 people who avoided a need for an emergency admission to North Devon District Hospital in Barnstaple
- There were 26 people who were cared for at home instead of being admitted to a community hospital bed in Torrington, Bideford or Holsworthy.
- An average of 2.6 people per month still needed inpatient care and this was provided either in Hatchlands (6) - a local residential and nursing care home or at Holsworthy or Bideford Hospital (25).
- 449 people received home based packages of care in 2012 but during the valuation a slightly higher number of 460 people received home based care but the number of visits per person increased (5669 visits in 2012 and 7760 visits in 2013)
- The numbers of visits per person increased from an average of 12.6 visits per patient to 16.9 visits per patient.
- The numbers of urgent community visits increased from 738 visits in 2012 to 882 visits in 2013. This is an important indicator in that urgent visit capability has a greater chance of avoiding unnecessary hospital admissions so is a positive indicator.

In summary positively - 100 older people had hospital admission avoided, a further 11 people not know to the community teams were supported with greater levels of input and six people who needed an inpatient bed had it provided in the town environs.
negatively a maximum 25 older people had to have their inpatient care provided in either Holsworthy or Bideford (we say maximum as even prior to the closure of the beds some patients needed to use the hospitals in Holsworthy or Bideford as there was not a bed in Torrington or there was a patient preference – usually family related)

7. Locality and Service area covered:

The test of change covers the area of Torrington, which is in the Northern locality of NEW Devon CCG. The population of the community is 12,512 (2011 Census) consisting of an older population than the Devon average, with high numbers of residents being aged 55-70 and a lower population aged 20-39. The number of older people within the population of Torrington is projected to rise sharply, and by 2026 the 65-84 age group is predicted to increase by 30.1% and the over 85's to increase by 60.7%.

There is a community Hospital in Torrington, which is managed by Northern Devon Healthcare Trust. Until 2013 there were 10 inpatient beds which provided care to the population, in the most part as a step down from treatment in the acute hospital in Barnstaple. The hospital now houses a number of inpatient services and is being developed as a health hub to provide more accessible healthcare closer to people's homes with a focus on improving the social element of healthcare provision. The hub will also provide support to the community teams, together focusing on more preventative healthcare. The result will be to avoid the need for as many urgent hospital admissions by identifying increasing needs of people with long-term conditions and reacting to these needs earlier.

Torrington Hospital beds have previously had no Consultant cover and so in the majority of cases of admitted patients to the community hospital have been from the two local GP Practices who are financed to offer medical cover for these patients. In terms of the impact of change, there are a number of considerations:

- If the available beds are predominantly used the two Greater Torrington Town GP practices, there is an immediate question about the equity of availability of beds for the Parishes who may receive medical oversight from different GP practices and therefore not have admission rights.

- If Torrington Hospital was to cease to provide inpatient beds, but attracted other speciality outpatient services, that would immediately extend the scope of provision to a population wider than those served by the Torrington town GP population. This could mean positively impacting on their need to travel and creating a critical mass for service delivery in Torrington rather than further afield.

- If the Torrington beds were not required there would be an opportunity to open up services for other than the elderly. This group would need to be identified, but could include young families, children and people with mental health difficulties.

The concept of providing a "Hub" based service is new and needs consideration but would suggest that all the below could be involved depending on the local requirements.

- Voluntary sector,
- Integrated social care with health, as exist already
- DCC, Place and People,

- Councillors
- Carers
- Independent Sector
- Existing staff

Public health data

A comprehensive overview of public health and associated data regarding the greater Torrington area is available in the Devon joint strategic needs assessment which can be found at www.**devon**healthandwellbeing.org.uk/**jsna**/overview

The town and surrounding areas of Great Torrington has an older age profile than Devon overall, particularly in the 55-70 population, but the proportion of people over 70 drops down to the average. This corresponds to what is often seen in smaller market towns, where older people migrate to larger market towns. Torrington also has a lower proportion of residents aged 20-39. Both of these fluctuations in population impact on the health outcomes of the town and surrounding area. There are a couple of noteworthy issues for this equality impact assessment

- Our older population is a little higher than the Devon average
- The black and minority ethnic community in greater Torrington is less than the Devon average
- Physical disability prevalence is lower than Devon average
- Mental health issue are higher than the Devon average
- The rate of carer's assessment per 1000 is the highest in Devon although not statistically significant.

With regards to older people the total number in the 65-84 age bands is predicted to increase by 700 people, a rise of 30.1%.
- The total number in the 85+ age band is predicted to increase by 204 people, a rise of 60.7%.

The life expectancy at birth of people living in Great Torrington is 87.9 years, which is higher (but not statistically significantly higher) than the average life expectancy at birth in Devon of 82.1 years. This is higher than the national average of 80.2 years.

In terms of the disease prevalence within Great Torrington (monitored by the Quality and Outcomes Framework or QOF for 2012-13) show where there is

likely to be greater need within the population. Circulatory conditions are all higher than the national average in the Great Torrington area, including Hypertension, Stroke and TIA and Coronary Heart Disease.

Health Conditions showing high prevalence in Great Torrington[1]:

	Castle Gardens Surgery	Torrington Health Centre	NHS NEW Devon CCG	England
Coronary Heart Disease	4.7%	4.7%	3.8%	3.3%
Stroke or Transient Ischaemic Attacks (TIA)	2.3%	2.5%	2.0%	1.7%
Hypertension	15.9%	17.8%	14.8%	13.7%
Diabetes Mellitus	7.0%	6.4%	5.9%	6.0%
Chronic Obstructive Pulmonary Disease	1.9%	1.8%	1.9%	1.7%
Hypothyroidism	3.7%	4.2%	3.7%	3.2%
Cancer	2.4%	2.5%	2.3%	1.9%
Asthma	5.7%	7.9%	6.6%	6.0%
Heart Failure	0.9%	1.5%	0.8%	0.7%
Heart Failure due to LVD	0.5%	0.6%	0.5%	0.4%
Palliative Care	0.5%	0.5%	0.2%	0.2%
Dementia	0.8%	0.7%	0.7%	0.6%
Depression	6.2%	3.3%	6.4%	5.8%
Chronic Kidney Disease	4.0%	5.1%	5.1%	4.3%
Atrial Fibrilation	1.7%	2.5%	2.0%	1.5%
Obesity	12.1%	12.4%	11.6%	10.7%
Cardiovascular Disease Primary Prevention	2.8%	2.9%	2.3%	2.2%
Peripheral Arterial Disease	0.5%	0.9%	0.7%	0.7%

[1] Priestley, K., Assessment of Service Usage and Health Needs in Torrington, 2014

The future population projections indicate that the population of Torrington who are 65-84 will rise by 30.1% by 2026 and the 85+ age group is predicted to rise by 60.7% in the same time. Subsequently this will result in a rise in the number of people living with long-term conditions.

8. What are the main activities of the project?

This test of change should provide two opportunities for clinical development and delivery:

1. It should:
    - Test and demonstrate the ability of the community team to deliver services that are as safe and are as good or better quality than the community hospital bed based model of care
    - Show that there are no negative and/or unintended consequences for health or social care across the health economy as a result of the change in the model of care.
    - Provide evidence that the model is sustainable from the point of view of the workforce
    - Provide evidence that it provides value for money
    - Is endorsed by the patients and carers that are in receipt of the new model of care as a quality service.

2. It should
    - Provide an opportunity to scope the additional services that could be commuted from Barnstaple to Torrington to provide a greater range of services for the local population closer to home.
    - Provide a platform upon which to open discussion and negotiation with the local authority (People and Place) about closer working within the community.
    - Provide an opportunity to open discussion and negotiation with the Voluntary sector about joint working and closer collaboration within the community.
    - Provide a basis for discussion about the involvement of the Independent sector in delivering care to the local community.

9. Who is intended to benefit from the strategy/policy/project, and how?

There are a number of potential ways that people should benefit from this test of change. Of the total population the greatest impact is on the elderly who are the greatest users of health and social care services although there are added benefits from other groups especially when considering improvements in midwifery, sexual health and family planning services in the community.

- Patients who would previously have been admitted to a community hospital can be cared for at home, improving their ability to remain independent and reducing the risk of admission to a long term care placement. This will cut down on travelling for patients how would have previously been expected to stay in the main acute hospital in Barnstaple for longer. (twenty mile round trip).
- Nursing services will be available for a longer period of time (8 am – 8 pm) allowing additional clinical and increased responsiveness to patients' needs. This allows for greater continuity of care for patients and family and increase the potential for people to be cared for at home more effectively.
- Additional and new clinics should be introduced in to the local community, benefitting all service users. The immediate increase from the consultation thus far would suggest benefits in moving , midwifery ante natal and postnatal care, sexual health and family planning, anxiety and depression services, community day care , including wounds and dressings, intravenous therapy – chemotherapy, transfusions and intravenous antibiotics. Additional investigations such as ultrasound could be offered and a transfer of acute surgical and medical clinics where there is sufficient needs to have visiting teams.
- The introduction of anxiety and depression services is a particular bonus and could lead to greater extensions to mental health services in the community reflecting the age range of the local community. Dementia support being a particular area for exploration.
- There will be opportunities for health services to work collaboratively with the third sector and the independent sector to deliver services, improving the quality of the services delivered and meeting needs above and beyond the scope of Health, for example delivering services in such a way as to address social isolation. This would occur through his development of a 'hub 'approach to the use of the facilities whereby closer working relationships on a day by day basis improve working patterns and processes.
- Staff should benefit from this test of change by having the opportunity to work in a more varied and clinically holistic way.
- Single points of access ensure there is better communication and reduces the need for patients to retell their story.

- People with physical disabilities have often made adjustments to their lives in their own home to enable them to be as independent as possible. It is default to replicate these in institutionalised setting and this can lead to a loss of confidence and/or independence; the aim of ensuring the optimum number of people are cared for tin their own home enables this level of independence to be maintained.
- People with learning disabilities find that changes in environment are unsettling, and can cause distress and anxiety; again remaining more frequently in home environments is a positive step.
- The same statement can be made for people with dementia or cognitive impairment. Admission to hospital can often create increased level of confusion and distress, impeding recovery from illness.

10. Is the policy consistent with the Trust's equality policies?

e.g. Acceptable Behaviour, Whistle Blowing, Zero Tolerance, Equal Opportunities

Yes

11. Is responsibility for the policy shared with another service, Trust or organisation?

New Devon CCG is responsible for the commissioning of services to meet the health needs of the population. The commissioning decisions made by the CCG need to have due regard for patient safety, clinical effectiveness, quality of service and value for money. The CCG does not dictate how services ought to be delivered but should concentrate on determining the right outcomes for people and ensuring commissioned services meet the required outcomes and quality measures.

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.

Northern Devon Healthcare Trust is the provider of the community service. 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 on 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.
11. If yes, what responsibility and which bodies? This new service model would be commissioned if the test of change proves to be of quality, safe and viable financially and in terms of sustainability, so there would be a shared relationship between provider and commissioner which will be managed through the contract using the normal mechanisms of governance and performance monitoring.

What impact is the strategy/policy/project likely to have on different sections of the community or employees? Please use the table below

	Impact – ✔ box	Reason	Are there additional factors that could contribute to the negative impact? If so, what are they?	Evidence/Consultation
Sex/Gender	None/positive	There is compelling research that home based care is a preferred by many people and has good clinical outcomes. Many people benefit from being cared for in their familiar environment and this project supports and increases in this.		All commissioned services are required to have suitable translation services in place for people whose first language is not English.
• Women	None/positive			
• Men	None/positive			
Race/Ethnic Group				
• Asian or Asian British people	None/positive			
• Black or Black British people	None/positive			
• Chinese people	None/positive			
• Gypsy or Roma People	None/positive			
• Irish People	None/positive			
• People of Mixed Heritage	None/positive			
• White People	None/positive			
• People of other ethnic backgrounds	None/positive			
Asylum Seekers and Refugees	None/positive			
People with physical disabilities	positive	Unfamiliar hospital surroundings create uncertainty and challenges for people how have limited mobility and dexterity. Remaining in the home environment		

	Impact – ✔ box	Reason	Are there additional factors that could contribute to the negative impact? If so, what are they?	Evidence/Consultation
		enables routines and familiar equipment to be optimised.		
People with sensory or learning disabilities	Positive	People with sensory or learning disabilities benefit from being cared for in their familiar environment and this project supports and increases in this.		
Deaf People who use British Sign Language	none			
People with mental health needs	Positive	There should be the possibility of increasing the clinic services for people with mental health difficulties		Depression and anxiety clinics now present in Torrington.
Lesbians, gay men and bisexual people	none			
Gender reassignment	none			
Trans people	none			
Pregnancy and maternity	none			
Age including	□□□			
• Older people (60+)	positive	There should be the possibility of increasing the number of clinics locally for the	This is the group of people who are more likely that any other to have been admitted to a community hospital bed. For those who need a specialist community beds, there will	See section 6 - 111 people were additionally supported by this test of change. Local end of life care for older people now available through local

	Impact – ✔ box	Reason	Are there additional factors that could contribute to the negative impact? If so, what are they?	Evidence/Consultation
		population of Torrington and its Parishes to access. The model of care could increase the opportunities for more people to be cared for at home and because of the age mix of the population this will be a positive benefit.	be no change as they would have gone to the appropriate other community hospital. For those requiring recuperative or End of Life Care there is the option of spot purchasing funding in the private sector close to home.	care home and home based care.
• Older people (60+)	Negative	A small number of people who may still need a community hospital bed may need to have this provider further from home.	This impact is acknowledged but felt that the increase in those who can be cared for locally with the new model outweighs the negative impact for a smaller group.	See section 6 a maximum of 25 but actually less were affected by this test of change.
• Younger people (17-25) and children	positive	There is an opportunity to offer addition al clinics and services for the whole of the population, not just the elderly who traditionally use the hospital beds.		Sexual health and family planning clinics now available in the town using facilities at the hospital. Midwifery services now available in the facilities at the hospital.
People of different faith groups or beliefs including non-believers	none			

	Impact – ✔ box	Reason	Are there additional factors that could contribute to the negative impact? If so, what are they?	Evidence/Consultation
Travellers	none			
Other (please specify)				
Carers	Both positive opportunities and risks	There is an opportunity to address the needs of carers more proactively using this model of care	The new model has to consider the impacts on carers, which if addressed fully as part of the planning process will enhance the support for carers. If more people are to be cared for at home there is a risk that pressure on carers could increase if insufficient support mechanisms are put in place. This must be addressed, by having adequate staffing numbers and skill mix, and closer working with voluntary and community support networks.	Highest numbers of carer's assessment now undertaken of any town in Devon. Mapping of carers services completed and more access occurring to support services.

Notes:

- Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when assessing positive and negative impacts.

- The categories relating to ethnicity include those used in the 2001 census. Consideration should be given to the needs of specific communities within the broad categories such as Bangladeshi people and to the needs of other communities such as Turkish/Turkish Cypriot, Greek/Greek Cypriot and Polish that do not appear as separate categories in the census.
- An adverse impact does not necessarily require action to be taken. Actions must remain in proportion with the benefits that could be achieved and resources available to complete them. If adverse impacts are identified and actions for improvement are not proportionate, the reasons for not taking action should be detailed and open to challenge.

12. Will this policy/service consultation be available in other formats, other languages? Braille, British Sign Language. Audio/video tape large print or statement acknowledging services are available in other formats.

Please see above, it is recognised that the scope of the service delivery will fall under the regulations pertaining to all NHS delivered services. In terms of the Test of Change itself, any related documentation can be produced in any language or format as indicated in the document “Meeting Local needs” and will be evidenced as part of the Engagement documentation.

13. Could you minimise or remove any negative impact?

All risks of negative impact are identified, as far as they can be in the evaluation framework and will be taken in to account as part of the overall evaluation of the test of change. The only negative impact is on those patients who are required to have their inpatient care away from Torrington, who would have been able to have it there previously. This is calculated as a maximum of 25 people and their families but is likely to be less as even prior to the closure not everyone wanting inpatient care in Torrington were able to receive it.

14. Could you improve the strategy, project or policy’s positive impact?

The service, particularly the provision of additional clinics will be subject to scrutiny and will developed in accordance with local need, financial viability and contingent on the success of successful local working relationships between health, social care and the voluntary and independent sector. This will form part of the test of change.
The intention will be to continue monitoring the impact of the change over time and to consider increases in population and the impact this has. This will be a local and a CCG wide need.

Please sign and date this form. One copy should be attached to the original policy/strategy/service change and published on the Trust website and Infopoint.

Elaine Fitzsimmons (associate) NEW Devon CCG
15.7.2014