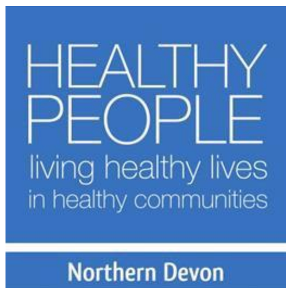

The permanent closure of inpatient beds in Torrington Community Hospital.

Joint Board Paper for NEW Devon CCG Locality Board and Northern Devon Healthcare NHS Trust

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Executive summary

NEW Devon CCG and Northern Devon Healthcare Trust commenced a joint "Torrington Community Cares" Test of Change (ToC) in July 2013 and concluded on the31st March 2014. It involved temporarily suspending the Torrington community hospital beds on the 1st 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.

The proposed way ahead which was being tested was to close the inpatient beds at Torrington, while continuing to provide an enhanced community care service, and increasing the range of non-admitting services provided at Torrington Hospital. Individuals from the Torrington area for whom a community hospital admission was still appropriate would be admitted to community hospitals elsewhere in the area.

In July 2014, both boards of the Northern Locality, NEW Devon CCG and Northern Devon Healthcare NHS Trust were due to make a long-term decision on the model of care, but agreed to defer the conclusion of the Test of Change (ToC), following discussions with Mr. Geoffrey Cox MP. This extension allowed the completion of four additional actions:

- Allow residents of Great Torrington a final 21 days to submit feedback about the experience of home-based care.
- The NHS to commission an independent evaluation of the Test of Change.
- The NHS to submit a completed dataset to the Oversight Group and in turn receive a recommendation from this lay-member group of community representatives.
- Hold a public meeting to discuss the conclusion of the ToC and outcome of the remaining actions with the local community. This meeting was held on the 8th November and chaired by Geoffrey Cox MP.

At key milestones, the evaluation data showed that the model of community care was safe. The evaluation of the home-based model of care has also been independently verified and found to offer a quality service to patients that meets their needs.

Preliminary evaluation and engagement reports were presented to Devon Health and Wellbeing Scrutiny Committee on the 16th June 2014; at this meeting, the joint engagement activities were passed without 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 offered from the Torrington Hospital building to enhance the clinic and day services available locally 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 during this process.

This paper is supported by a number of full and summary documents which are provided as appendices to this paper.

Background

The management of the Torrington inpatient facilities has long been a challenge to sustain; with issues of staff retention coupled with questions about the whether the use of inpatient beds at Torrington was the right care for people who did not necessarily need community hospital beds for clinical reasons. The inpatient beds at Torrington hospital were used for a number of reasons which were not necessarily the responsibility of the NHS, for example, holding beds for delayed discharge packages or respite which should be funded from elsewhere.

In 2010 the 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 evident to patients, the

other more focused on organisations. There was an agreed and phased increase in community based staffing – more funding was made available for therapy and nursing staff: both qualified and support staff, were increased with a longer working day for community nurses from 8 am until 8 pm seven days a week. Other services were funded through S256 (NHS funding transfer to the Local Authority).

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

As a consequence of the phased increase in community resources, admissions to Torrington community hospital were decreasing year on year and the further increase in community services in this test of change reduced the bed needs further, which made the inpatient service vulnerable to clinical sustainability and patient safety risks.

Evidence collected to support the proposed change.

During the 'Test of Change '(ToC), it was 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.

At the earliest opportunity, face to face engagement with the community to answer questions and hear concerns was undertaken. Many of the concerns heard were converted into data capture fields – such as A&E attendances and NDDH admissions, average length of time of home visit - to provide public assurance throughout the Test of Change that care was not being put at risk and that issues important to the public were being reviewed.

Throughout the engagement process, the NHS took a flexible approach and took great care to respond to the communication needs and concerns of residents. In response to feedback from the general public the NHS stated that it want to ensure that the enhanced community care was as good if not better than the in-patient care.

It became clear that this statement was an impossible concept to demonstrate because there was no baseline measure of the quality of the inpatient care in Torrington Hospital prior to the closure of the beds, but also because comparing the care of a number of patients admitted to the hospital with the greater number cared for in the community would be a methodological challenge and would require definition of what criteria were being used to measure this.

This challenge was acknowledged; nonetheless every attempt was made through the evaluation and the engagement to find data which helped us to understand the consequences of the changed model. NDHT also continued to collect and process feedback on services from PALs, patient experience, complaints and compliments as well as patient safety metrics which are routinely collected such as SEAs (Significant Event Audits) and SIRIs (Serious Incidents Requiring Investigation) which are all regulated processes for the analysis of any adverse incidents in the NHS. A review of the data suggests there has been no increase in trend.

The Test of Change also includes an evaluation of the impact on other parts of health and social care systems to uncover any 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.

The Evaluation Framework also describes a clear line of sight between the National Health and Social Care Outcomes Frameworks, and the detail that was captured across the health economy to demonstrate the impact of the community model of care.

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 expressed its commitment to work in partnership with the community to develop services that could meet the needs and aspirations of the Torrington Community and its surrounding parishes.

The NHS approach was to maintain the investment for enhanced community care and enhance the range of services at Torrington. The questions posed to the public allowed for the option for

the public view about beds, as well as questions about what other services might be appropriate at the hospital.

The message from some members of the public was a desire to keep beds but also have the enhanced community services. The NHS has been clear throughout that maintaining both service types in their current model was not affordable, but acknowledges that this may not have been as explicit as it might have been. In order to be able to fund the (inpatient and community) service as desired by some members of the public for Torrington, the NHS would have needed to take service funding from elsewhere to be able to provide it.

We now know that Devon is one of the most financially challenged areas in England in terms of funding the NHS. Against this context, our first priority is to bring the NHS services back into financial balance to be able to ensure we protect and sustain core services. Even if we could redirect funding to Torrington the choices that would have been presented in order to achieve this were:

- Remove funding from other community-based services to provide for Torrington which would increase inequity for other communities by reducing their provision.
- Close beds in other communities to be able to afford the beds in Torrington, but with no ability to invest the additional money needed in those other communities for community based services (indeed this happened when it was agreed that beds needed to be reinstated for 8 weeks at the start of the ToC and 10 beds at South Molton had to be closed to compensate).
- Restricted elective activity to reduce the contract income for Northern Devon Healthcare Trust and further afield to redirect the resources to Torrington. This would have meant that the public of Northern Devon would have had a lower level of access for elective care at NDDH than other areas of Devon without any good clinical justification.

None of the above would have been neither palatable nor clinically sound decisions.

Engagement and involvement with the community started in July 2013 with briefings for key community leaders. The anxieties and anger expressed by the public about the Test of Change were incorporated into the evaluation data sources and were attended to as part of the overall approach. The most commonly heard concerns were made the subject of hosted focus groups and hospital Tour and Talks to ensure the community could take an informed view on the issues of most concern/interest.

Details about how the 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 requested 'safety net'. The engagement approach taken was mapped against NHS England's requirements and standards for robust patient engagement.

To ensure that many different voices were heard throughout the ToC, including STITCH (Save the Irreplaceable Torrington Community Hospital – the local action group), many different ways of engagement and involvement occurred. The full engagement report describes the various events and opportunities that were offered for engagement.

Key to this work was the voice of the patients who were receiving home-based care. 6 patient stories were completed, three of which were developed into a film which can be seen on the specially convened website:

http://torringtoncares.co.uk/patients-say/feel-receive-care-home-torrington/

At the time of the ToC, regular monitoring of patients experience who were receiving care in their own homes was not commonly undertaken by the NHS. The Northern Devon Healthcare Trust introduced patient experience surveys for those patients who had received home-based care from therapists (physiotherapists and occupational therapists). This survey was given to patients at the point of discharge from the community team and then extended to the nursing team.

A patient experience report including the Friends and Family Test (patients are asked to think about the service received and state whether they would recommend the service to their friends and family) is included in the Engagement and Involvement Report.

To capture themes from those Torrington residents admitted to another community hospital, the Trust continually reviewed feedback from other community hospital inpatients to identify any particular issues from this patient group. None were raised via this feedback route. In hindsight it may have been helpful to specifically target these patients and their families to understand any unexpected challenges, although at the same time the CCG was consulting on its Care Closer to Home Strategy which raised a number of issues especially transport availability, visiting times and discharge planning, all of which would be relevant for Torrington residents in other hospitals.

There were some very positive aspects to the engagement opportunities that supported this

ToC although it was recognised that there were aspects which could have been improved upon. The NHS team was always flexible and responsive in their approach, continually developing activities based on feedback. We received very positive feedback from the public about their experiences of these opportunities. Very good relationships developed 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.

In July 2014, the Boards and executives of the Northern Devon Healthcare Trust and NEW Devon CCG Northern Locality agreed to fulfill a further four actions before the Board met to make a final decision on home-based care in Torrington.

As outlined in the introduction, these final actions were;

- Independent evaluation of data supporting Test of Change: this was commissioned from Dr Helen Tucker an independent healthcare consultant and vice chair of the Community Hospitals Association.
- Allowing a further and final 21-day period for the community to submit their experiences of care in Torrington: Northern Devon Healthcare Trust reviewed the submissions using their usual patient involvement and complaints processes where relevant.
- Submitting a complete dataset to the Oversight Group and convening a final meeting where a recommendation would be offered, before the NHS Boards make a final decision. (The additional data included the further two months data so a full six months was available, social care data and staff feedback. The STITCH dossier was also provided in full and a précis).
- Hold a public meeting in Torrington, chaired by Geoffrey Cox MP to present actions: the meeting was held on 8 November 2014.

In the independent report, Dr. Tucker acknowledges the considerable amount of data collected, has verified that it is accurate and praises the flexibility in the engagement process as a result of feedback. She does criticize the engagement process for the ambiguity felt by the community as to whether this included the opportunity to influence any decision about the reinstatement of inpatients beds. She cautions that the interpretation of the data is limited by the relatively short timescales during which it was collected however she states that "the overall conclusion that the new model does not have a negative impact on the whole system and the wider community would appear to be a reasonable assumption".

The Board papers include some additional information recommended for inclusion by Dr. Tucker and the oversight committee. Also, a summary of the two NHS organisation's response

to Dr. Helen Tucker's report is included, as well as a response from the two organisations to the comments made about the process.

Evaluation of the clinical impact

The six month Clinical Evaluation Report is complete and can be found as Appendix 5, and presented in summary form in, Appendix 6. The level of rigour provided to the testing of the clinical data was significant and undertaken jointly by clinicians from across the community. Clinicians are the most challenging of changes to models of care and as they carry the clinical risk and need to be completely confident that the new models do not compromise patient safety. This report is positive and the model of care tested in Torrington between 1st October 2013 and 31st March 2014 has shown to:

1. Be as good in terms of health and social outcomes as the service delivered from ten community beds.
2. Be clinically safe.
3. Demonstrate no negative impact on the local health or social care system of Torrington and its Parishes nor further afield in Northern Devon.
4. Be more productive in terms of the community services available
5. Reduce "exposure to risk" in hospital (infections, falls etc.) and also creates less institutionalisation of elderly patients. (Devon County Council correlates this with the decrease in residential placements they are experiencing in Great Torrington.

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 Northern 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).

The recommendations from the Oversight Group which met on the 31st October are summarised in the following statement:

"In an ideal world we would wish to recommend that the Community Hospital beds and Community services run concurrently, fit for the 21st Century. However, due to current financial constraints, we recognise this is an aspirational recommendation, although in general we have not seen evidence that the quality, reliability and safety of patient care is being compromised in

the existing model, we proposed the following recommendations:

1. The oversight group committee should continue to hold the providers and commissioners to account and refer them to the following:

- *The presented data analysis represents trends, not statistical significance ;*
- *The numbers of patients/carers are relatively low and have been assessed over too short a period of time;*
- *The study is generic and can be perceived as lacking focus on a potentially vulnerable group of elderly patients;*
- *A number of patients appear to have been disadvantaged – particularly during the early stages of the process (i.e.: regarding discharge procedures and patient choice)*

2. The process of change should be reviewed regularly i.e.: initially at six monthly intervals (With reports to the Oversight Group).

3. There should be a particular focus throughout these reviews on all aspects of service delivery (e.g. sustainability and patient/carer and workforce experience)

4. In light of the fact that the OSG would have wished to focus greater attention on the concept of the Health & Social Care Hub:

A separate community focussed group should be established, to consider and contribute constructively to the emergent use of the Torrington Community Hospital as a Health, Social Care and Voluntary sector `Hub'; promoting integrated care, ill health prevention, carer support etc.

Financial Viability and Sustainability

The home-based 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.

	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 in subsequent guidance and are as follows:

- Support from GP commissioners
- Clarity on clinical evidence base
- Strengthened patient and public engagement
- 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.

Both provider and commissioner are responsible for ensuring that people impacted by a change in service provision are involved in the process of change that their feedback is listened to and acted upon. This includes service users and staff.

Support from GP Commissioners

The Northern Locality Board members of the CCG have been involved from the outset in the Test of Change and have gained assurance 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 it is also acknowledged that this is a difficult conversation for individuals who are members but are also providing services for 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 meeting.

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 26th November 2014 and will take the ultimate decision on whether to commission the home based model in Great Torrington.

The Board of the Northern Devon Healthcare NHS Trust has also discussed the Test of Change on many occasions, the most recent and thorough of which was the July 2014 meeting of the Board. The presented papers and minutes can be found here

http://www.northdevonhealth.nhs.uk/category/trust-board-meetings/

Care of the Elderly consultants at the Northern Devon Healthcare Trust have been actively involved in, integral to the design 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 and providing rigorous interrogation of the data.

Clarity of Clinical Evidence Base

There has been a national policy drive to move services out of acute hospitals and in to the community since 1990. A consultant in Public Health in Devon has conducted a review of national and international evidence on our behalf. 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."*

Their 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 focused 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.

The patients and carers who have experienced the home-based care service value it, as evidenced through the Friends and Family Test scores (of +75). NDHT has a target of a minimum of +60. Any score above +70 is extremely positive as the (net promoter score) formula is extremely sensitive to criticism.

Although we heard considerable objection to the loss of the beds, the Great Torrington community also voiced and recognised the significant benefit to the wider community of the increased community infrastructure and the possibility of developing a community health hub out of which other services could be provided. Indeed all new services that were launched in Torrington from November 2013 were following community feedback and analysis of need /referral patterns to determine those services for which there was most need for.

The NHS understands and appreciates the strength of feeling, especially around concerns about the loss of services, and has listened to all views expressed. The NHS does need to make difficult and often unpalatable decisions based on clinical safety, quality, sustainability of care models and affordability. The increased investment for community services cannot continue alongside the retention of the costs associated with a bed-based model of care.

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 Devon,

"Save the Irreplaceable Torrington Community Hospital" (STITCH) action group, Devon Senior Voice and the Drop in sessions conducted by Torrington Town Council.

From analysing the content of these third parties engagement activities it became apparent that there was an expressed desire for beds, but the meaning attached to those beds included functions for which those beds would or should rarely be used such as convalescence and respite.

Neither convalescence nor respite requires the clinical services of medical inpatient hospital staff; end of life care 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.

Where appropriate the CCG will continue to commission Community Hospital beds – although the numbers and location are subject to the separate evaluation and engagement process relating to the Northern locality commissioning intentions. The CCG and Devon County Council also continue to commission care from nursing homes in the locality when appropriate.

Feedback during the engagement processes undertaken led the CCG to commission some improvements 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 has reduced complexity and eased access to the service for relatives, carers and patients. 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 4 co-ordinator was appointed and this again has proved effective, and an important function in making sure planning for discharge is safe and effective. Discharge planning is a key function for the transition between community and hospital and one which can increase confidence and reassurance for patients and their families.

- There was a desire to increase the number of options for clinics and services to be made available locally. Northern Devon Healthcare Trust has actively moved clinics

and services from NDDH to the Torrington Hospital site. The range of clinics and services has increased significantly and are now 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). To do this, a band 6 day-centre nurse was employed part time but this has now increased to full time.

- The needs of carers were identified in the Equality Impact Assessment and in conversations with the public as a group requiring support. It was acknowledged that there could be an unintended impact on the carer and family and concern that pressure may increase as a result of more care being delivered in the home setting. The CCG commenced a project to map all local support for carers with the objective of ensuring that these services are more clearly identified and more likely to be used. This project is continuing with Devon County Council. It has been highlighted in the scoping completed that there are a number of services which can be accessed to support carers in Northern Devon, but this access relies on a carers assessment and there are delays in this being undertaken. The process by which the assessments are undertaken more quickly are being reviewed at the current time.

The engagement approach was comprehensive and accessible, responding to the needs of the audience. Over 15 months it included face-to-face meetings, drop-ins, public meetings, focus groups, a trip to Budleigh and a consistent volume of letters, freedom of information requests, public relations activities and media relations.

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. A provider is an organisation commissioned to provide health services for communities. Northern Devon Healthcare Trust is the only provider of community healthcare services in northern Devon.

One of the Torrington community's challenges 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; this is based on need defined by clinicians.

It has been noted that the new model of care increases choice: patients now have the choice of being supported to remain healthy and independent in their own home. This choice was limited pre-2011, but more people benefit now. Patients can still be admitted to a bed when needed, 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). We can also use the alternative of nursing home beds with clinical input from the community teams where this is an option and enable people to have bed based care closer to home where a community hospital is not available.

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 benefit from the community based model.

In future years, should demand increase, the model of home-based care is also scaleable, i.e. investment in community staff numbers to care for more patients. It also enables us to have a firm foundation for new technologies for example telemedicine. We know that the technological advances have had a profound impact on the way clinical staff provide care and supervision to people and will continue to do so. Torrington hospital building would never be able to expand to provide space for more than 10 inpatient beds.

During the ToC, the number of patients on the community caseload only increased by 11, (from 449 – 460), 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 support them at home. We also know that people would prefer to be cared for at home, when it is clinically safe to do so.

The statutory duties on choice set out in the NHS commissioning Board and Clinical Commissioning Groups 9 responsibilities and Standing Rules Regulations) do not apply.

The Board should have regard to the Duties of the CCG under s 14 V of the 2006 Act
14V Duty as to patient choice. Each clinical commissioning group must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

The proposed model of provision preserves and indeed in some areas enhances the options for care available to patients, albeit that in relation to admission to a community bed, this will

no longer be available in Torrington hospital under the current proposal.

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

(This section includes legal extracts)

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.

S 242 applies to Northern Devon Healthcare NHS Trust. The equivalent provision for the CCG is set out in section 14Z2 of the 2006 Act.

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
(a) in the planning of the commissioning arrangements by the group,
(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(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

It is fair to comment here, as in other places that a valuable lesson has been learnt about preparedness to be actively engaging with the public at all points in the commissioning cycle, so that by the point any consultation is required, our approach is already shaped to meet local need more accurately. This is not intended to be an excusing factor but our process effectively became hijacked as our intention was to ask about services for the community but rapidly focused on the narrower question of the potential loss of beds. This impact was acknowledged in the feedback from the Devon Health and Wellbeing Scrutiny Committee.

Hard lessons were learnt 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 henceforth, and there is good evidence that despite this difficult start the engagement did lead to real changes and improvements in the model of care and processes which were meaningful and important to patient and their families.

The CCG also needs to have regard to the duties set out in S14P- 14Z1 of the 2006 Act, in particular to the requirement in relation to equality of access and outcome, and having regard to the improvement in the quality of services, as covered in the next section.

Responsibilities of the CCG under the Equality Duty Act 2010

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

- ✓ Gender reassignment

- ✓ Pregnancy and maternity
- ✓ Race – this includes ethnic or national origins, colour or nationality
- ✓ Religion or belief – this includes lack of belief
- ✓ Sex
- ✓ Sexual orientation
- ✓ Age
- ✓ Disability

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

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
- **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 Assessment 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. The precise numbers are detailed in the Equality Impact Assessment but are highlighted below

- 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 community inpatient care and this was provided either in Hatchmoor (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 Test of Change a slightly higher number -460 - people received home based care and the number of visits to patients at home 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, making this a positive indicator.

In summary positively - 100 older people had hospital admission avoided, a further 11 people not known 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.

In summary negatively - a maximum of 25 people had 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).

We need to continue to explore the needs of carers and families for patients who are cared for away from Torrington in other community hospitals. Flexibility of visiting times and transport are two key referenced issues.

The Gunning Principles

The National Institute for Health and Care Excellence (NICE) issued advice and guidance on the Gunning Principles in March 2014. Their briefing summarises NICE's recommendations for local authorities and partner organisations on how community engagement approaches can be used to improve the planning and delivery of all services, including those that impact on health. It is particularly relevant guidance for Health and Wellbeing Boards, of which Healthwatch Devon is a member.

[5] The Gunning principles (propounded by Mr. Stephen Sedley QC and adopted by Mr. Justice Hodgson in R v Brent London Borough Council, ex parte Gunning [1985] 84 LGR 168). [1]The principles say that:

- Consultation must take place when the proposal is still at a formative stage.
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account.

These give a description of the NHS Act responsibilities described previously. Again this reinforces the message that if there is regular and planned dialogue with the community throughout the commissioning cycle we will be able to clearly evidence that consultation has taken place during the formative stage. It underlines that the Board is still in a position to take

[1] They were endorsed by the Court of Appeal in the Coughlan case, and have recently been endorsed by the Supreme Court in R (Moseley) v Haringey LBC

a decision which may not be in accordance with the recommendation – no prior decision determines the outcome of this process.

The evidence provided by the Public Health analysis provided an overwhelming justification for starting the pilot in line with a good evidence base and national policy direction. However, the recent Supreme court decision in R (Moseley) v Haringey London Borough Council made it clear that a consultative process must include information about the alternatives that have been rejected (in that case alternative funding for the shortfall arising on the change from Council Tax benefit to a local council tax rebate scheme.)

There has been extensive discussion of the alternative of retaining the beds at Torrington, although as noted above there has been less discussion of what the CCG would have to do if it were to contemplate running both services. That option has certainly been suggested, notwithstanding that the Oversight Committee acknowledged it as unaffordable.

There has been adequate time for consideration and response over and above any statutory requirements and there is evidence that delays have been factored into the process to allow for further consideration.

There is good evidence that the products of the engagement have had a direct influence on the model design, but it remains for the Boards to exercise the function of conscientiously taking the feedback from the exercise into account in making their decision.

Conclusion

The independently verified data which has been collected, and, despite some acknowledged limitations, has indicated:

- Safe care for those in receipt of community health and social care support in great Torrington.
- no negative effects in respect of increased hospital or A&E attendances,
- no increased workload for GPs,
- An overall reduction in length of stay by 28 days for all patients in Great Torrington.
- Fewer patients have been admitted to hospital as a result of the enhanced community support. This results in less overall need for relatives to travel long distances to make visits because their family member is still at home and not in hospital.
- An important saving in overall costs.
- The model is clinically sustainable and can be ‘scaled up.’
- In line with national policy direction.

The quality of inpatient care before the test of change had not been specifically measured as part of the evaluation, but had been reported as very good. The concerns of the community about difficulties for families travelling to alternative hospital sites if an inpatient bed is required are acknowledged. Both NHS organisations have confirmed that where an inpatient bed is required there is a commitment to ensuring that Bideford will be the location of choice wherever possible, unless the person and their family request an alternative. There is also acknowledgement for people being discharged from acute hospital care there may be occasions that the length of stay may be slightly longer but avoid the need for a community bed and the person will go directly home with good discharge plans in place.

Running both enhanced community care and in-patient community hospital beds in parallel cannot be afforded and although the relatives of those patients admitted to hospital may be disadvantaged with further distances to travel, more families are likely to benefit with no need for travel because hospital admissions are fewer than before through adoption of the enhanced community care.

Concern has been expressed about an increased burden on carers and about the isolated patient with no immediate family or neighbors. Isolation is cause of considerable anxiety which is why a system of spot purchasing of nursing home beds in the Torrington area where it is medically indicated is in use and the CCG is prioritising the increase in carers assessments in its work with social care.

Questions about how the new service will cope in severe winter weather were reasonable because access to remote areas along narrow ungritted lanes are annual challenges that all services must overcome. Fortunately this only occurs for a few days each year and mitigating this problem is a regular part of winter planning and operational NHS business continuity plans. Most patients seen by the community teams would already be on their workload whichever model is adopted. The intensity of input will be different for a few patients over that winter period. This is not seen as an issue entirely relevant to Torrington but an annual part of operational planning.

Furthermore there are major challenges in recruiting registered nursing staff both locally and nationally. The new model which does not require 24 hour staffing is likely to prove easier to staff than a community hospital with inpatient beds.

There are some other general factors which have been emerging as the CCG and NDHT continue to work together:

- The learning from the Mid Staffs Report on standards of care is being referenced regularly and influences our views on acceptable clinical practice. This becomes apparent when there are discussions regarding lone working issues, clinical supervision and peer support. Community hospitals as they are currently configured create particular challenges for the clinical teams.
- Lack of resilience in small hospitals and the risk of short term and sudden closure or withdrawal of services.
- Increasing appetite from the public to engage in conversations about services which would be better provided closer to home and in partnership with social and the voluntary and community sectors.
- Finances – it is now clear that the NHS in Devon is financially challenged and, is currently spending more than it receives. This cannot continue.

After considering these factors, summarised above and detailed in the accompanying documents, the following recommendations are made to the Boards of both organisations.

Recommendations

Northern Devon Healthcare Trust

The Northern Devon Healthcare Trust Board agrees 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.

The Northern Devon Healthcare Trust Board agrees 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.

NEW Devon CCG, Northern Locality Board

The Northern Locality Board of the CCG 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.

The Northern Locality Board of the CCG 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

- Confirmation that the temporary closure of the inpatient beds will become permanent will be immediate.
- For The Northern Locality of NEW Devon CCG the decision of the locality Board will be shared with and noted by the Governing Body.
- The clinical commissioning group will commit to ongoing monitoring of the changed model of care in partnership with Northern Devon Healthcare Trust. This will include a process of reviewing qualitative and quantitative data which must include detailed feedback about the patient and community experience.
- Work will continue in earnest to develop further the concept of the community hub, in order to bring as many services as possible closer to home for benefit of the community.
- The health and wellbeing committee will be asked to receive an update report in the spring of 2015.
- The health overview group will be asked to review the model of care and report back to as described in the summary of their findings.
- The clinical commissioning group will contractualise the changed model of care, with an updated specification which will include key outcome indicators for effect from the new contracting year 2015/16.

Appendices

1. Evaluation framework Board paper Torrington

2. Terms of reference for the oversight group Board paper Torrington

3. Six month engagement full report Board paper Torrington

4. Six month engagement summary report Board paper Torrington

5. Six month clinical impact evaluation – full report Board paper Torrington

6. Six month clinical impact evaluation – summary report Board paper Torrington

7. Public Health review of clinical evidence of the effectiveness of home based care Board paper Torrington

8. Equality impact assessment Board paper Torrington

9. Appendices for Engagement Report