Northern, Eastern and Western Devon Clinical Commissioning Group

New Devon CCG and North Devon Healthcare Trust to the comments from Dr Helen Tucker.

This is a summary of the views of the two organisations reflecting on the comments made by Dr Helen Tucker in response to the Torrington evaluation. Dr Tucker had been commissioned to provide an independent assessment of the evaluation. In doing this she highlighted a number of areas and offered her views on the content. We are extremely grateful to Helen Tucker for finding the time to evaluate our work and engagement with the Torrington Community, She completed this work in a very short time and it has been invaluable in allowing us to improve the quality of our reports to the Boards of the CCG and NDHT before any decision is made about the future use of Torrington Hospital. We highlight in this response where we have taken on board her suggestions and comments. We also explain where we have not acted upon her suggestions and clarify why this is so.

Changes have not been made to the evaluation document as this is in the public domain, but this is intended to demonstrate that consideration has been given to her points of view which were very much appreciated; there are of course lessons to be learnt in term of process and presentation and these are described below.

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1	**Test of change:** Dr Tucker suggests there was: 'Confusion regarding the nature of the pilot or test of change, as assumed if unsuccessful original	We acknowledge that confusion arose, despite our best efforts to ensure clarity of approach. In our initial document "Meeting local needs" we asked on page 11 'so do we need fewer in-patient beds or none at all? Should the hospital be used instead for other services? We believe it should'. We later stated in our summary of Torrington Community Cares Engagement and Involvement Final Report (Summer 2014). 'We were not engaging on whether the model of care worked or whether the in-patient beds should be reinstated. We were engaging on what services the residents of Greater Torrington would benefit from being able to access from Torrington hospital rather than NDDH' p10 of 11 Helen Tucker has paraphrased this statement (personal communication) on page 8 of her report under the heading of 'Scope of the Evaluation' as the re-instatement of inpatient beds at Torrington Community Hospital was not an option and not for negotiation.

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	service would be reinstated.'	This is incorrect. Our emphasis was on the wider use of the physical space in Torrington hospital but despite the acknowledged difficulties being faced in staffing the hospital in-patient beds, we wanted to both hear the voice of the community and ensure that the new model of care was safe before making any decision on the in-patient beds. We share Helen Tucker's observation that this message was not made clearly enough.
2	**Focus of the evaluation**. Dr Tucker's commented that there was the: 'Expectation of each element of the TCC model (was) being evaluated such as changes in inpatient experience and an increase in clinics etc. in TCH'.	We accept that we missed the opportunity to include the quality of in-patient care in Torrington hospital prior to the test of change. Reports of the care in the hospital from the community were positive but we have omitted to capture this in any objective way. We would recommend that the Boards, when making their decision, weigh the likely positive benefits for those patients who would have been admitted to Torrington hospital as well as a possible detriment to their care under the new model against the much larger number who have received enhanced care in the community and the reported outcomes of that care.
3	**Communication.** 'TCC website needs updating, and includes some negative patient and carer experiences which may not help with confidence in the model'	We have updated the website. In trying to be as balanced as possible we included some negative experiences. It was not the intention to undermine the model but to acknowledge that no system is perfect and that the NHS has used the experience of patients to continually improve the care we provide. We still believe that inclusion of mixed experiences was correct
4	**Baseline.** 'An expectation that there would be a clear articulation of the community hospital service with inpatient beds (status quo), a case made for change, and then	As acknowledged above, we did not undertake a full assessment of the status quo as we did not believe we would be able to make a direct comparison with the new model. There was significant information collated that showed there was a need to do something different to provide healthcare. The drivers for change were, as already stated in our engagement documents, • the national and international research evidence, • the opportunity of obtaining funding to enhance the community nursing service,

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	a comparison with new model but this was not carried out.'	• the decline in the use of the Torrington hospital in-patient beds over years • The use of beds for non-healthcare reasons • The increased difficulty in staffing the hospital safely.
5	**Value.** 'The community is concerned that the local NHS does not appreciate or recognise the value and trust that they place on their local community hospital and the importance and quality of community hospital care is not reflected in any of the key documents.'	We have always acknowledged the high regard in which community hospitals are held by their communities. We accept that we had not given sufficient weight to the community's value placed on beds and the trust placed in those beds in their local community hospital. This has now been acknowledged in the Board papers.
6	**Evidence.** Although we presented sound evidence for the new model 'No analysis of evidence for all elements of the community services, such as community inpatient care, although the issue of patient selection indicates that some people will still need this service.'	We have always stated that this model did not make the case for no community hospital beds at all. But it does demonstrate that fewer beds would be needed and that for a community the size of Torrington it would be difficult to clinically or economically justify the small number of beds required on the basis of patient safety and nursing standards.

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7	**Use of data.** 'The presentation of the data was considered to be confusing and needed to be interpreted within context of small numbers and short timescale'	We note this comment.
8	**Current activity.** 'No analysis of activity to answer concerns such as completed visits/missed visits, complaints/compliments/ waiting times for services and equipment, readmissions etc. also no impact on other community hospitals"	The staff Did Not Attend (DNA) rate for appointments in people's homes was halved during the pilot. There was a slight increase in cancelled attendances which was no greater than the percentage cancelled by patients themselves. This is described in the appendix of the evaluation. This has also contributed to wider work looking at the way community teams plan their visits. The impact on other community hospitals was assessed in the Board papers submitted to NDHT Board meeting in July 2014. (NDHT reference annex 2.4 evaluation document section 7 pages 10-13) The impact on other Community hospitals was assessed in the Board papers presented in July (NDHT reference is annex 2.4 evaluation document, section 7, pages 10-13
9	**Patient experience.** 'No measures of experience of patients who have had alternative care to TCH inpatients'	At the four month stage, every patient who had the enhanced service (i.e. those we could recognise as patients who would have been previously admitted) was invited to speak to NH Engagement Officer about their experience. All of those who agreed were interviewed. Each interview was recorded. The transcript was made and sent to them for checking and cross checked by Healthwatch to ensure what was said was correctly represented in the text. These are in the appendices of the engagement report.

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10	**Review of patient episode.** 'Unclear in the report how the case note reviews led to conclusions made. Also how issues such as clinicians concern about patients in outlying community hospitals and recorded inconvenience was being addressed.'	A medical timeline was completed for every one of the ten patients. The process undertaken was a clinical review and validation of the person's experience to assure clinicians that the right pathway of care was offered. This was also an opportunity for the group of clinicians which included primary and secondary care to consider if the care could have been provided in a different or better way. The opportunity was taken to confirm that where a hospital bed was used it was needed, thus the note about inconvenience was identified but the purpose of the clinical review was about reassurance of the right clinical pathway. Patients were offered more distant hospitals on occasion but it was confirmed that a hospital bed was necessary.
11	**Cohort of Patients.** 'A cohort of patients (frail older patients assessed needing a community bed) are considered to be disadvantaged as they will have a CH bed outside Torrington or a nursing home bed and it is unclear what safeguards there are for these patients and their carers'	This is addressed in the Equality Impact Assessment. Specifically for the disadvantaged patients, we will aim to admit these patients, if needed, to the nearest community hospital, unless their preference is to go further afield. This has been confirmed in the Board paper.
12	**Nursing Home beds.** 'Need to address whether spot purchasing is a sufficiently robust arrangement, as it is dependent on there being an available nursing home bed	There is an accepted risk that a nursing home may close or not have insufficient beds to permit spot purchasing when required. This risk may not be greater than the risk of all community hospital beds being full when a patient requires a bed. We (CCG) will be considering how to manage this risk as part of the whole Care Closer to Home project and this may include a block booking of some nursing home beds to ensure availability if found to be necessary. The partnerships directorate of the CCG are undertaking an assessment on our behalf

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	locally.'	as part of the engagement process to determine bed availability and capability and will provide an assessment about a reasonable number of beds to be considered as part of the bed configuration for the future.
13	**Patient stories.** 'STITCH has collected 17 patient stories contributed as evidence, showing issues with lack of access to CH beds and difficulties with home care'	Please see separate appendix summarising these stories and the stage to which responding at what stage we have got to in responding to the complainants. We would also refer you to the full STITCH dossier. Please see the separate appendix summarising the sorties and the review stage for each case. We would also refer you to the full STITCH dossier of which six relate to issues of access and quality of care. Four cases require a response and this is in progress.
14	**Engagement Outcome.** 'Responses to Meeting Local Needs question not yet adequately captured in the draft evaluation and engagement reports'	We structured our engagement approach around the themes identified in workshops We acknowledge the challenge we experienced in encouraging the community to discuss their health need, as opposed to whether or not beds should remain in Torrington. The whole engagement approach was flexed and structured around themes that the community wanted to discuss including beds, but also end of life care, access to services, growing old and home-based care. Going forward, and once a decision has been made about the model of care in Great Torrington, we will be far more able to progress the engagement activities to discuss meeting current and future health needs and what services are offered from the Hospital.
15	**Wider public engagement.** 'The Evaluation and the Engagement Reports do not adequately reflect the outcome of the surveys carried out by community organisations such as the Parish Poll, Devon Senior Voice, Healthwatch and notes at public meetings.'	There is an action plan that pulled out all the themes from Healthwatch, Devon Senior Voice and the council drop-ins that captured all the themes not picked up in the evaluation framework. The key themes are in the reports, for example travel.

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16	**Formal consultation.** 'No formal consultation although it may be deemed that there has been a significant change of service (closure of beds)' …and therefore requires formal consultation	Devon Health and Wellbeing Scrutiny Committee (Devon County Council) passed the six month evaluation documents without restriction. Their advice was that there is no restriction from scrutiny that would prevent NEW Devon CCG and Northern Devon Healthcare NHS Trust proceeding. The Committee requested 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://wwwdevoncc.public-i.tv/core/portal/webcast_interactive/118309.
17	**Report on evaluation.** 'Scope to be clearer about how the evaluation has proved the objectives and how this leads to a recommendation.'	This is acknowledged and the Board paper for each of the organisations has been amended to make this much clearer.
18	**Evaluation phases.** 'The presentation of the data in separate timescales is confusing for the later version of the report and could now be simplified, with detail of changes over the period referenced in working documents'	We accept this. And have made efforts to improve the presentation but are mindful that the documents are already in the public domain.
19	**Report on Engagement.** 'The report is not comprehensive, it does not include the wider engagement activities led by the community/Healthwatch etc., does not capture outcomes sufficiently and has yet to make recommendations'	We have made this section more comprehensive and included some recommendations as a result of the feedback gathered. Please see answer to item 15.

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21.10.2014 final