Northern, Eastern and Western Devon Clinical Commissioning Group

Response from NEW Devon CCG to the questions asked at the public meeting held on Saturday 8th November, chaired by Mr Geoffrey Cox in response to the Torrington developments.

Despite 11 cases of alleged failure of patient care the CCG has persisted with the claim that the new model is safe, sustainable and provides a quality of service that is as good if not better than before. How can this be the case?

The questioner, we believe is referring to the 17 cases presented by STITCH for investigation and 2 additional letters from the public received as part of the 21 day extension.

Of these, because of timing 7 could possibly refer to the new model of care, but only 4 of the total 19 requested an investigation; 1 related to discharge from NDHT, 2 related to co-ordination of care by community nurses and 1 related to access to physiotherapy. The investigations are still on-going; whilst any complaint is disappointing it is not clear yet what lessons need to be learnt to contribute to the continuous improvement of the model of care. The numbers do need to be balanced against the total of 970 patients cared for in the community during the same period.

What will be the level of displacement of people from Torrington who will have to go to other community hospitals? What is an acceptable level?

Over the first 6 months of the test of change, on average 2.5 people from Torrington per month required community hospital placement. This demonstrates our commitment to ensure that patients who do need a bed continue to be able to access one, even if not in Torrington. We also need to remember there IA a commitment to use locally spot purchased beds in care homes if this is a suitable and preferred choice.

Was there a policy of moving patients away from Torrington Hospital before the test of change?

No. There has always been a history of a small number of patients being placed in other hospital beds even while the Torrington beds were open. This is because Bideford is the only community hospital with a specialism treating stroke and South Molton has a specialist orthopaedic pathway, so all orthopaedic patients needing a community hospital would be placed there , even when the Torrington beds were open. The other group of patients who would often choose another location would be end of life care when the family and the patient will jointly select another hospital as this is more convenient for them.

Surely a breakdown in communication between community staff is a safety issue and should be taken into account?

We are not aware of any breakdown in communication between community staff. We did note that there could be improved and greater ease of communication for discharge

planning and adjusted our model of care to improve this by adding discharge co-ordination time into the model.

Dr Tucker's report states that hospital at home care does not necessarily reduce overall costs so why the hospital beds can't be restored?

Dr Tucker is right to identify that the overall cost of delivering care in Torrington for the NHS and social care is about the same when the cost of the beds is compared to the cost of community services. However, if we were to revert to the beds, just a maximum number of 10 patients would benefit at any one time, whereas the number managed in the community is considerably greater. Therefore if there is choice in funding beds or community services we believe that we get more service for our community by moving away from bed based care where clinically safe to do so.

By using the finances to fund care in the community, more people can be seen, they receive more visits and visits can last longer, therefore more people benefit.

In addition, if the building can then be used to run more clinics that people would ordinarily have to travel to Barnstaple for, a further cohort of patients derive benefit from the new model, which is over and above the direct beds versus community service debate.

We do have a very simple comparison for costs which suggest that the average cost per inpatient stay in a community hospital beds is £7451 per episode, and a patient cared for in a hospital at home scheme averages £2879 per episode. This does need to be treated with caution as some of case load of a hospital at home scheme will not have the same level of input of clinical and social care.

Why are we getting more services for our money by using the new model than the hospital beds?

Please see above

Is cost an issue?

The allocation of funds to a community and it a subsequent use in the broadest sense is an issue for the NHS and the Councils. Any changes being made need to consider that we have an obligation to spend only within our allocated funds, so it would be disingenuous to say that money is never an issue. For health services in Devon, we have to recover our £14.6 million overspend this year and £430 million over the next five years. We are one of the most financially challenged communities in the country, but our intention is to ensure with the work we are undertaking that the proportion of our spend in community services does not diminish.

It is therefore really important that we can demonstrate that we are getting the maximum amount of healthcare for our money.

Should the whole process be restarted considering there is no systematic review or evaluation of the inpatient unit performance prior to the model of care so nothing to compare with?

There was detailed analysis and evaluation of the use and function of Torrington community hospital beds, through public health and data analysis going back to 2010 / 2011. The work Dr Tucker alluded to that was not undertaken was a qualitative review of the patient experience in those beds. However, since the evaluation was with regard to

the community service it could be argued that the two baselines would not be comparable and the existing information therefore did not make up part of the evaluation report.

This is a really subtle but important as the hypothesis we were trying to test was – do we need beds if we have improved community services? And then we moved to - were community services a safe model of care? – thus our intention was never to ask beds or community services and indeed our model has shown that there are some patients that will always need a community bed because their clinical need can't be met in the community, or it is more cost effective for them to remain in a bed.

How can you make a final decision on projections?

The outcome of the evaluation produced trends. We have also reviewed the subsequent six month data set to demonstrate that the changes in patient outcomes were maintained. These have been shown to be consistent now over 12 months and are retrospective, based on data, not forward projections. At some point we do need to say we have enough information to be confident that the change is sustained. We believe we are now at this point.

The model of care in Torrington is based on an urban design yet 75% of the population live in rural areas. How can you justify using this model?

We don't recognise a rural or urban model, but have worked towards a model that suits the needs of the Torrington community. This means we have had to take into consideration, the population needs, existing capacity and gaps, rurality, and other factors to consider the model for this community. We know going forward in North Devon that whilst we may have a core model for a community team it will be varied to reflect local need.

Have you measured the downtime of the community staff when they are travelling to and from appointments?

Yes we have. First we analysed the travel times for all staff in all the Complex Care teams. We found that travel time made up around about 17% of total time for all staff and that those in built up areas spent more time traveling than those in rural areas as they got caught up in traffic queues far more frequently.

Then we re-calculated the Torrington travel time as part of the test of change. Although more staff was travelling, increasing the total mileage, each member of staff spent less time traveling and more time with patients in face to face contact.

Who will be responsible if there is a death that could be avoided as a result of the new model?

All patients who are referred to the community team receive a clinical assessment and a package of care is designed with them to best meet their needs. If they are to stay in the community, the GP is responsible for their medical care, as has always been the case.

All untoward deaths are routinely referred to the coroner and this would continue to be the case. No one would be retained in the community if it was not being deemed clinically safe to do so. If there is sadly a death and it could have been avoided wherever this may be the relevant members of the clinical team will be held to account.

How is the model of care going to be monitored and will we be able to change it if it's not working?

This model has been scrutinised since the beginning of the test of change. This has included analysis of data to suggest whether the model was safe, community activity, feedback from patients and feedback from clinicians.

Then the provider has internal mechanisms for on-going monitoring of their own systems and processes, including monthly meetings about the model and service delivery, supervisions, weekly meetings with the various members of the community team, including GPs and support from PALs and complaints. All of these lead to service change and development when and where that is required. Additionally we have asked the oversight group to continue to meet to also provide some independent rigour to our internal processes.

What is the true cost of care closer to home in Torrington, including all of the various aspects? Where do we find the costing?

Care Closer to Home and the test of change in Torrington are not the same, so it is difficult to provide an accurate answer. The Torrington test of change calculated the cost of moving people who would have been in hospital to care and not the full range of services we would like the community to provide under care closer to home to offer preventive health, avoidance of admissions, long term management, crisis management and long term especially end of life care.

The direct like for like costs for Torrington are shown in the Evaluation and Summary documents. This is only part of the overall Care Closer to Home plan and was a test of change to develop the model of clinical delivery in to a community.

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What about between 8pm and 8am when you may only have one or two nurses on duty if an elderly patient has a fall?

The Out of Hours services will be looked at as part of Care Closer to Home as part of the development of Urgent Care and was never part of the test of change in Torrington.

If an elderly patient does fall in the night, the right thing to do is call an ambulance. Such a patient would never have been admitted to a community hospital. Nor would any patient be admitted to a community hospital "just in case" they should have a fall.

If a patient is deemed vulnerable, the options would be to refer them to the falls and balance service and/or open a question about whether remaining in their own home is their wish, or when the right time would be to consider different accommodation.

What happens if there is so much pressure on the nursing staff that they become ill?

Part of the test of change was to make sure we had got the right number of staff for the right number of patients. It is not acceptable for so much pressure to be placed on staff that they become ill and it is the joint responsibility of the Provider and Commissioner to make sure this doesn't happen. We also recognised that the increased number of staff on their own was not the full answer but there was a need to resolve some of the communication issues and processes so that staff felt their time was valued and their clinical skills well utilised.

Why was Torrington chosen for this particular pilot?

Torridge was chosen by the Strategic Health Authority (SHA) in 2010, because they were keen to test models of clinical working in ruralities. In discussion with the two complex care teams, it was agreed that Torrington should receive all the funding because they had the poorest staffed services and at the time the most fragmented clinical services. Therefore there was the potential for the biggest gain to the community service availability.

Is there a plan in other parts of Devon for this model to be rolled out?

If Northern Devon Healthcare Trust Board and the Northern Locality Trust Board are convinced by the safety, quality and sustainability of the test of change, it will be used to support and inform the development of complex care teams across the Northern Locality. We do know that whilst a broad model can be described each community will have its own unique needs which need to be factored into the developments.

How many patients have been sent to private nursing homes and had to pay for their care?

Over the first six months, 6 patients were placed in a private nursing home, but since they were still receiving NHS care, the NHS paid for their placement.

How many nursing home beds are available at one time for spot purchasing and at what cost?

The number of beds available is variable, as is the cost, depending on the home that is being used. In Torrington, the numbers equate to on average 1 placement per month.

Are there any 24 hour packages of care in place? If so, how many?

There are no 24 hour packages of care in place at the moment. If someone needed actual 24hour clinical care it is envisaged this would be the type of patient who would be cared for in a hospital bed.