Devon County Council

Phil Norrey
Chief Executive

To: The Chairman and Members of the Health and Wellbeing Scrutiny Committee

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

(See below)

Your ref :
Our ref :

Date : 10 June 2016
Please ask for : Gerry Rufolo, 01392 382299

Email: gerry.rufolo@devon.gov.uk

HEALTH AND WELLBEING SCRUTINY COMMITTEE

Monday, 20th June, 2016

A meeting of the Health and Wellbeing Scrutiny Committee is to be held on the above date at 2.00 pm in the Committee Suite, County Hall to consider the following matters.

P NORREY
Chief Executive

A G E N D A

1 Apologies for Absence

2 Minutes

Minutes of the meeting held on 8 March 2016 (previously circulated).

3 Items Requiring Urgent Attention

Items which in the opinion of the Chairman should be considered at the meeting as a matter of urgency.

4 Public Participation: Representations

Members of the public may make representations/presentations on any substantive matter listed in the published agenda for this meeting, as set out hereunder, relating to a specific matter or an examination of services or facilities provided or to be provided.

MATTERS FOR CONSIDERATION

[*NB. Please note that the times shown below are indicative and while every effort will be made to adhere thereto they may vary although, normally, items will be taken before the time shown*]

5 Torrington Community Hospital Task Group (Pages 1 - 40)

2.15 pm

Report of the Task Group (CS/16/05) attached

6 South Devon and Torbay Reconfiguration (Pages 41 - 66)

2.45 pm
Report of South Devon & Torbay CCG (PH/16/20) attached

7 Community Services in Northern Devon: Update (Pages 67 - 88)

3.10 pm
Report of Northern Devon Healthcare Trust (PH/16/19) attached

8 Cancer Treatment Waiting Times (Pages 89 - 90)

3.40 pm
Report of RD&E NHS Trust (PH/16/22) attached

9 Wider Devon Sustainability and Transformation plan and NEW Devon success regime Progress (Pages 91 - 98)

3.50 pm
Report of the Success Regime (PH/16/21) attached

MATTERS FOR INFORMATION

10 Information Previously Circulated

Below is a list of information previously circulated for Members, since the last meeting, relating to topical Health and Wellbeing developments including matters which have been or are currently being considered by this Scrutiny Committee:

(a) Response by the Scrutiny Officer after member consultation on the annual Quality Accounts from RD&E Hospital Trust, Devon Partnership Trust, North Devon Hospital Trust and the Torbay and South Devon NHS Foundation Trust;

(b) Press Release: Outstanding for Caring - but CQC inspectors find Torbay and South Devon NHS Foundation Trust Requires Improvement;

(c) Minor injury services in Sidmouth: outline of changes;

(d) CQC launch of a new 5 year strategy for 2016 to 2021;

(e) Devon Patient Transport Advice Service (PTAS) information poster and new telephone contact;

(f) Spotlight on rural health: newsletter by the Rural Health Network, part of the Rural Services Network;

(g) Update on Transforming Community Services and the transition of adult complex care services in the Eastern Locality to the Royal Devon & Exeter NHS Foundation Trust;

(h) Press Release regarding a report on End of Life Care – 'A different ending: Addressing inequalities in end of life care';

(i) Financial Times article on proposed increase in rents for health providers;

(j) Information on NHS organisations publicly ranked on their openness and transparency under a new 'Learning from Mistakes League' launched by Monitor

and the NHS Trust Development Authority.

.

PART II - ITEMS WHICH MAY BE TAKEN IN THE ABSENCE OF THE PUBLIC AND PRESS

Members are reminded that Part II Reports contain confidential information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s).
Members are also reminded of the need to dispose of such reports carefully and are therefore invited to return them to the Democratic Services Officer at the conclusion of the meeting for disposal.

MEMBERS ARE REQUESTED TO SIGN THE ATTENDANCE REGISTER

Membership
Councillors R Westlake (Chairman), R Westlake (Chairman), C Chugg, A Boyd, J Brook, C Clarance, P Colthorpe, G Dezart, P Diviani, R Gilbert, B Greenslade, G Gribble, E Morse, D Sellis, E Wragg and C Wright and C Wright Representing District Councils Councillor J Christophers
Declaration of Interests
Members are reminded that they must declare any interest they may have in any item to be considered at this meeting, prior to any discussion taking place on that item.
Access to Information
Any person wishing to inspect any minutes, reports or lists of background papers relating to any item on this agenda should contact Gerry Rufolo on 01392 382299 Agenda and minutes of the Committee are published on the Council's Website.
Webcasting, Recording or Reporting of Meetings and Proceedings
The proceedings of this meeting may be recorded for broadcasting live on the internet via the 'Democracy Centre' on the County Council's website. The whole of the meeting may be broadcast apart from any confidential items which may need to be considered in the absence of the press and public. For more information go to: http://www.devoncc.public-i.tv/core/ In addition, anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chairman. Any filming must be done as unobtrusively as possible from a single fixed position without the use of any additional lighting; focusing only on those actively participating in the meeting and having regard also to the wishes of any member of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chairman or the Democratic Services Officer in attendance so that all those present may be made aware that is happening. Members of the public may also use Facebook and Twitter or other forms of social media to report on proceedings at this meeting. An open, publicly available Wi-Fi network (i.e. DCC) is normally available for meetings held in the Committee Suite at County Hall. For information on Wi-Fi availability at other

locations, please contact the Officer identified above.

Public Participation

Devon's residents may attend and speak at any meeting of a County Council Scrutiny Committee when it is reviewing any specific matter or examining the provision of services or facilities as listed on the agenda for that meeting.

Scrutiny Committees set aside 15 minutes at the beginning of each meeting to allow anyone who has registered to speak on any such item. Speakers are normally allowed 3 minutes each.

Anyone wishing to speak is requested to register in writing with Gerry Rufolo (gerry.rufolo@devon.gov.uk) by 0900 hours on the day before the meeting indicating which item they wish to speak on and giving a brief outline of the issues/ points they wish to make.

Alternatively, any Member of the public may at any time submit their views on any matter to be considered by a Scrutiny Committee at a meeting or included in its work Programme direct to the Chairman or Members of that Committee or via the Democratic Services & Scrutiny Secretariat (committee@devon.gov.uk). Members of the public may also suggest topics (see: https://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/scrutiny-work-programme/

All Scrutiny Committee agenda are published at least seven days before the meeting on the Council's website.

Emergencies

In the event of the fire alarm sounding leave the building immediately by the nearest available exit, following the fire exit signs. If doors fail to unlock press the Green break glass next to the door. Do not stop to collect personal belongings, do not use the lifts, do not re-enter the building until told to do so.

Mobile Phones

Please switch off all mobile phones before entering the Committee Room or Council Chamber

If you need a copy of this Agenda and/or a Report in another format (e.g. large print, audio tape, Braille or other languages), please contact the Information Centre on 01392 380101 or email to: centre@devon.gov.uk or write to the Democratic and Scrutiny Secretariat at County Hall, Exeter, EX2 4QD.

Induction loop system available

Health and Wellbeing Scrutiny Committee

Torrington Community Hospital Task Group

June 2016

1. Recommendations

The Task Group ask the Health and Wellbeing Scrutiny Committee, Cabinet and the NHS in Devon to endorse the report and recommendations below. The Task Group also recommends that the Health and Wellbeing Scrutiny Committee receives a progress update in 3 -6 months' time.

Recommendation	Detail	Organisation
Specific to Torrington		
1) The report be sent to the Success Regime and to the following: ⇒ Copy to the Secretary of State for Health ⇒ Copy to the local MP ⇒ Copy to Torridge District Council and Torrington Town Council	The Task Group remains unhappy with the situation in Torrington; however the grounds upon which to make a referral to the secretary of state have not been fulfilled. The future of the health landscape in Devon will be determined by the Success Regime, this report and findings must be understood in this context.	Scrutiny
That Torrington Hospital is further developed as a healthcare hub to serve the whole population of the area	Scrutiny to have sight of plan for action within twelve months.	CCG
General recommendations		
2) Meaningful, comprehensive communication to be undertaken with local residents and stakeholders BEFORE strategic decisions are taken by the NHS.	The Task Group cannot emphasise this enough. Consultation may not always be technically required but engagement and communication are essential. Scrutiny wishes to see evidence of local people involved in determining the future of local provision. 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). 1The principles say that:	CCG/Provider

[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

Recommendation	Detail	Organisation
	• 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.	
3) Clinical audit to be carried out before changes are made to community hospitals.	This is a recommendation taken from discussion with Dr Helen Tucker, this measure would give a greater evidence base to assist the evaluation of future change.	CCG
4) All agencies to articulate the purpose of a community hospital – why is it there and what services would we expect to see from it.	Differentiation between local hubs and inpatient facilities with clarity over what treatment patients can expect to receive. This would also assist the discussions at strategic evaluation level.	CCG/Provider
5) Develop the capability to harness the power of the wider community.	The strength of feeling in Torrington has demonstrated the untapped potential to support the strength of the community, this should be meaningfully engaged.	DCC/CCG
6) Review the appropriate provision in end of life care throughout Devon. Ensure that there are adequate residential care and nursing beds throughout Devon	Future report to come to Health Scrutiny to include costings and breakdown of number of available beds in each locality.	Scrutiny/CCG/DCC
7) Lobby government to develop a consistent approach to community hospital provision across the country.	Write to local MPs	DCC
8) The Scrutiny Committee to monitor the average length of stay in community hospitals and review actions taken to reduce.	Future report to come to Health Scrutiny	Scrutiny/CCG/providers

2. Introduction

2.1. The subject of Community Hospitals has been considered at length by the Health and Wellbeing Scrutiny Committee at Devon County Council. The future of Community Hospital Task Group concluded in September 2012 and made recommendations about moving beyond a bed-based model of care. Since this time significant changes have been made to community hospitals in Devon and more are planned, with the Transforming Community Services Programme and similar in South Devon and Torbay.

2.2. The starting point for this investigation was whether or not the committee wished to make a referral to the Secretary of State for Health (Health and Social Care Act 2001, sections 7 – 10).

The investigation focussed upon the following lines of inquiry:

- To clearly establish the principles upon which any referral can be made to the Secretary of State for Health.
- To review the evidence and process by which decisions were made about Torrington Community Hospital to ascertain if there is a case or desire by the committee to make the referral.
- To consider the steps that the committee might take in future against the backdrop of significant changes to community hospital care in Devon.

2.3. The Task Group has met nine times and spoken to 29 witnesses as well as inviting contributions from members of the public and other interested parties in the form of press releases. The Task Group has also received written representation from Geoffrey Cox MP (Appendix 4).

2.4. There are two distinct parts of this investigation and subsequent report;

1. The first has sought a resolution to the question of whether the consultation was sufficient, and that the changes were in the interests of the people of Torrington. Asking the question that the Task Group was set up to make a recommendation on – whether or not the changes in Torrington should be referred to the Secretary of State for Health.
2. The second part of the investigation has been to establish the evidence base upon which changes across the community hospital landscape of Devon should be made. This was a widening of the original scope to attempting to understand the nature of the issues in Torrington and how the challenges and problems faced by local people might be applicable to changes across the whole of Devon.

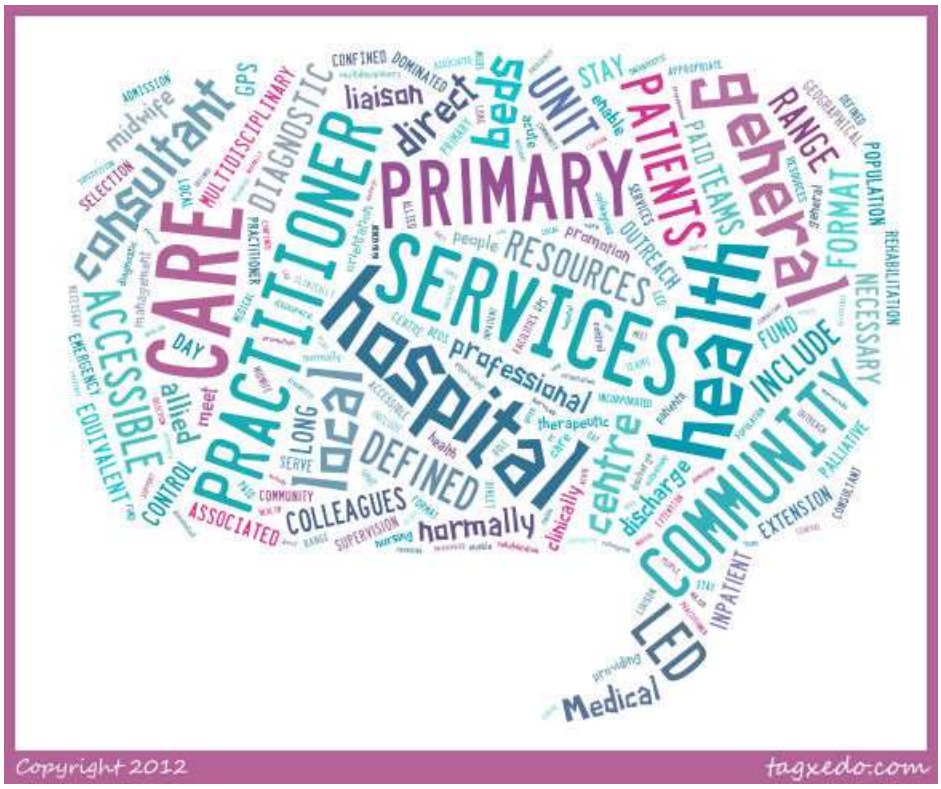
2.5. This investigation has taken place against the backdrop of much change in the NHS. Locally the Success Regime has been invoked to support the NEW Devon health system move to a position of financial sustainability. This carries the implication of changing models of care and the Scrutiny Committee have witnessed the difference in approach to some traditional pathways of care. It follows that there are instances where a community hospital is not the best place for treatment and these may be different to what was appropriate in the past. However this does not undermine the principle of local hospital beds or local treatment, but requires an articulation of the best use supported by evidence based policy. Any recommendations and conclusions of this report need to be considered in tandem with the recommendations and actions proposed by the Success Regime.

2.6. The Task Group expects to see developed rehabilitation and support in Community Hospitals to enable patients to have short stays with a strong focus on evidence-based intervention. Community hospitals are a valued medical resource and must be used to their best advantage.

2.7. The Task Group will place on record its dismay at the breakdown in communications over change and the situation in Torrington where residents have consistently felt that their views were not heard or listened to.

3. What is a community hospital?

3.1. There is no consistent definition of what constitutes a community hospital. The Scrutiny Community Hospital Task Group report of 2012 spent some time considering the implications of the lack of a comprehensive definition. That Task Group created a word cloud to summarise the commonalities between different definitions which is worth reproducing:



3.2. One word that is no surprise to see in large font is 'hospital'. But given the variation in provision, as discussed further on in the report, should we apply the same term to all health care settings that have evolved to be called community hospitals? The previous Task Group requested differentiation between the terminologies used to reflect the significant differences in provision offered.

3.3. The term 'community hospital' was first used in the 1970s, when Dr Rue and Dr Bennett developed a model of a community hospital in Oxford Regional Health Authority. This took the original concept of a cottage hospital and widened its role. The model of a community hospital was complementary to acute hospitals and had a strong focus on rehabilitation. Ideally, community hospitals would have health centres or GP practices integrated as part of the overall facility. One of the first examples was Wallingford Community Hospital.

3.4. Today in the area covered by Devon County Council there are 26 community hospitals, 9 presently provided by Torbay and Southern Devon Health and Care Trust. Community Hospitals play a crucial role in taking pressure off acute hospitals both by treating patients locally so they don't have to go into an acute setting and by transfer out of an acute hospital as part of the rehabilitation process. They are also playing an increasing role in providing outpatient clinics and diagnostics and in some settings there is more scope to extend this. Rehabilitation is a key role of the community hospital and the patient profile tends to be older than the average in an acute setting.

3.5. There is systemic frustration with the current situation where community hospitals have evolved across the County with varying services offered. This creates disparity, inequality and uncertainty about what services will be on offer where. Local residents are understandably opposed to changes where the perception is one of loss, where a strong case has not been made and they will not be in receipt of an improved service. This was particularly the case in Torrington where changes have happened in advance of most other areas in Devon.

4. Torrington Community Hospital

4.1 The situation in Torrington has been clouded by speculation, misinformation and a lack of clarity in engagement. For the Task Group to ascertain the facts it has had to review at length what local people have said as well as to understand the position of the NHS and local decision makers. The situation has been very unfortunate, and in hindsight was made more so by the temporary closure of beds for safety reasons. A complication of the investigation has been that the Scrutiny Committee has been kept informed of the process in Torrington at a strategic level throughout the discussions and the closure of the beds. This means that looking afresh at all of the evidence is empirically problematic.

What are the facts?

4.2 Torrington hospital had 10 beds which, on average, were used by 90 people per annum. The length of stays could be significantly longer than ideal which was picked up by the Scrutiny Community Hospital Task Group in 2012.

4.3 The beds in Torrington were closed on the 1st October 2013, for a 'test of change'. The idea of this was to close the beds for a limited period and carry out analysis over the impact to inform the future provision. Unfortunately this move was highly confusing to all involved giving the feeling of a predetermined outcome.

4.4 To attempt to remedy the situation the CCG reopened six beds for an 8 week period as the new service was being established and as consultation and engagement activities were taking place. The beds then closed at the end of November.

4.5 The CCG did have concerns over maintaining the adequate staffing of the unit as well as the most appropriate treatment pathway for patients. Before the test of change there were questions being asked about the sustainability of the service. This was shared with scrutiny at the beginning of the process.

4.6 A prolonged and detailed programme of discussion took place in the community, (See appendix 2) however since this was simultaneously built upon a lack of trust and a campaign to keep the beds, it is difficult to determine how local relations could have progressed in a positive manner. The NHS has no requirement to consult on short term changes which are in reaction to safety measures, but this becomes very confusing when combined with long term strategic decisions.

4.7 Some Torrington residents were so animated by the process that they formed a campaign group to demand patient choice be taken into account and the beds in Torrington be reopened. The NHS did develop a stakeholder group to manage the change and engage with the local community, this was not universally successful.

What do local GPs say?

4.8 There was a local GP position statement produced on the 17th March 2014. This stated that GP's felt that it was right and proper to explore how best to spend the finite resources available for services but they had concerns over the costs and that the care closer to home fund could be subject to further NHS cuts. In addition they felt there was a core group of patients who needed the beds.

4.9 As part of the Task Group investigation members went to a local GP surgery and spoke to a GP who had been in post for some time. The Task Group was informed that the use of the beds might have been an asset to the town but that in the last eighteen months before they closed patients were staying for prolonged periods of time and securing a bed for a patient was very difficult. In light of this it was felt that a different model might have potential to treat more patients.

What do the public say?

4.10 The pressure group, Save the Irreplaceable Torrington Community Hospital (STITCH) have deep rooted concerns that the plan in Torrington was always to remove the beds and that the 'test of change' was simply the quickest way to remove the beds and then retrofit the evidence to the scenario. They have protested at length that the change was not what local people wanted and that enhanced care was not what the community were experiencing. There is much anger in the community at the way the situation was handled.

4.11 STITCH wrote to the Task Group, protested at Scrutiny Committee meetings and the Task Group visited Torrington to speak to the group. The strength of feeling cannot be overstated. STITCH has strong links to the Town Council, and the Town Council offices were used to host the meeting. The town Council has consistently called for a referral to the Secretary of State on this issue.

4.12 The Task Group was so concerned about the strength of feeling that it repeatedly called on local people to come forward to share their concerns about current care. (Appendix 5). Fifteen people responded directly to the news story on the Devon County Council website. In addition two people got in contact and e-mailed scrutiny. Those that were directly in contact with the scrutiny Task Group were invited to speak to the group but did not indicate a wish to.

4.13 Many of the comments are lamenting the loss of the beds in the community hospital. Scrutiny analysed the responses, looking for commonalities around the concerns. Whilst some of the concerns could be said to be cavilling there are many of a more substantial nature. To understand the issues and get to the heart of the matter the Task Group have summarised the concerns that have come from STITCH and other members of the public into two parts; the process in Torrington and the concerns on the ground now:

The process in Torrington

- The beds were closed without prior notice or consultation
- No impact assessment was undertaken prior to the closure of the beds, giving no baseline to evaluate from. This means that evaluation of which service provides the best care for patients is not possible. It should have been independently researched and evaluated.

- Local people do not feel that their views were taken into account despite the community conducting a petition, referendum, surveys etc.
- Confusion over what the consultation could actually determine. It was on the services offered by the hub not on the option of reinstating the beds.
- Costs and savings of the new model are not clear.
- Disagree over the system providing 'enhanced' care.

The future of community care in Torrington

- There are not enough beds in the area, be it nursing home or community hospital, to accommodate those who require them.
- Transportation issues with the rural nature of Torrington. Both for nurses taking longer to reach people and patients travelling further for treatment.
- There appears to be a massive gap in the discharge service from the district hospital.
- With a community hospital care was 24/7, with care closer to home your care time is allocated and if an accident happens there is no support.
- Respite provision continues to be an issue
- There is anecdotal evidence that visitation times are being cut
- End of life care (where can people choose to die?)

Patient Stories: Discharge in the middle of the night from the District Hospital

- The patient in her late eighties was taken by ambulance to A & E. She was discharged on her own in the early hours of the morning. Fortunately she knew a taxi firm and contacted them to collect her. The driver was very concerned for the lady's welfare.

- 80 year old lady stoma in place. Discharged without having an evening meal, stayed all night at home with no care, had no one at home. Only seen the next day.

- Young couple – lady had to go in for day surgery, couldn't get there in time. Discharged at 3 in morning. £40 taxi – had to take out a pay day loan. Better promotion of car scheme.

- Young mum was taken to hospital by ambulance. She was discharged at 3 the morning. They have no car and no family in the area. She was told to call a taxi which cost £40- Money that the couple could not afford - and they had to take out a pay day loan to cover this cost.

[2]

HealthWatch Devon

4.14 Healthwatch carried out a survey in Torrington during summer 2013. Over the course of 3 days, a local team, including Healthwatch Devon, stopped 167 people in

[2] Evidence submitted to the Task Group by STITCH who assert that if the community hospital had been open then the issues experienced with North Devon Hospital would not have occurred. However the task group has not received evidence to support this assertion, and the patients may not have been treated in the community hospital, had the beds been avaliable.

the street and asked them their views on the Community Hospital. The following is an extract from the conclusion:

'There is a tangible perception by our respondents, (who are mostly aged between 41 and 75, who had mostly heard of this development by newspaper reports and word of mouth via street collection of views,) that the public engagement process is a pretence, that a decision to permanently remove the inpatient beds has already been made and is a precursor to closing the hospital. Moreover, there is a suspicion that this decision is being driven by financial pressures. Most people's involvement had been through reading newspaper reports and the minority of people had attended a workshop. More respondents had been to a drop in and/or public meeting where they were able to hear first-hand from commissioners and providers.

There remains, however, mistrust by some local people of the CCG and NDHCT and this is impeding a constructive dialogue about future healthcare in the Torrington area.'[3]

What does the NHS say?

4.15 In lengthy sessions with both commissioner and providers the Task Group has heard that the NHS acknowledges the less than satisfactory way that engagement and consultation was carried out, although significant engagement was undertaken. The NHS recognise the importance of involving patients and the wider public in shaping local services, although the ultimate decision about best value for public money does reside with the CCG.

4.16 In Torrington there was increased community staffing on a gradual base from 2010 which resulted in a year by year decreasing need for community hospital inpatient beds. This went hand in hand with difficulties in recruiting staff to work in the community hospital and resulting in the decision to close the inpatient beds on the grounds of safety.

4.17 There has been extensive engagement with the community, adapting engagement to suit the local need as part of the process. This caused confusion. The NHS did not clearly state what the engagement plan was at the outset. A fully published engagement document was later developed. The process continued for the best part of the year and included written documentation, as well as drop in sessions, which changed to tour and talks. This is detailed in Appendix 2.

4.18 As part of any change the NHS has to meet the four Lansley tests. At all points through the change in Torrington the NHS has been confident about meeting the 4 tests.

4.19 In Torrington part of the historical issue has been that staffing shortages meant that the beds were closed for safety reasons. When the test of change was being planned, short term temporary changes were made that did not require engagement/consultation.

4.20 In an effort to maintain the close working relationship with NDHT, the CCG supported NDHT's decision to close the beds on grounds of safety (lack of nursing staff). This confused the public as it was interpreted as part of the strategic plan. In retrospect it would have been better if the CCG had insisted that the beds stayed open until after the test of change.

4.21 The result was that communications with the community were reactive and clunky. Actually there was much work in the Torrington area to develop community services

[3] HealthWatch Devon http://www.healthwatchdevon.co.uk/wp-content/uploads/2014/05/HWD1-Torrington-200-Survey-proofed-Publication-Copy-V1-28-5-14-FINAL-BRANDED.pdf

which started in 2010 but these were not visible to the public. The gaps in communication left the community to draw their own conclusions. Whilst this was not technically a breach of any requirement it was significantly unhelpful.

4.22 In November 2013 the law changed (case law) and now any service change requires a period of engagement/consultation if it is deemed to be substantial, even if it is temporary. This would now include the temporary closure of community hospital beds. This change had the effect of muddying the waters further[4]. Before July 2012 the system was to make a change and then inform the public about it: under the new Health and Social Care Act 2012 the emphasis moved to co-creation with the public being involved at an earlier stage in the process. This was a whole shift in the modus operandi for the NHS and public alike.

5. Are Patients disadvantaged by the changes?

5.1 This is a key question in the consideration in any referral to the Secretary of State. This is also a question that Dr Tucker considered at length. There are two parts to the answer of this key point; firstly are the patients that would have been treated in a community hospital receiving similar or improved service, and are other patients receiving an enhanced service as a result.

Current or existing patients

5.2 The Task Group must rely on the information submitted throughout the process by the NHS as there is limited scope to independently ratify numbers. According to published figures, there are approximately 2 - 2 ½ people needing continuous 24 hour care in the Torrington area.

5.3 Concordant with the increase in investment to support home-based services 449 people received home based packages of care in 2012 but during the evaluation 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).

5.4 In some cases patients would go to a nursing home instead of a neighbouring community hospital. Those that are in a nursing home will usually have therapy interventions. Where the community team would provide therapy rehab and the care home would provide the environment.

5.5 Information from NDHT and NEW Devon CCG analysing the 18 months of the Torrington test of change data shows that there were 132 fewer admissions to hospital from patients living in Torrington postcodes than in the time when the community hospital inpatient beds were in use and prior to the investment in enhanced community health and social care teams.

5.6 This suggests that these community health and social care teams are effective in caring for patients at home who would have previously been admitted to hospital. It would generally be expected that over time the increase in elderly people would increase the number of patients admitted to hospital. This may not be statistically significant over the time period, but would indicate that a reduction in admissions is against the expected trend.

5.7 Another measure of the success of a model of care is the rate at which patients have to be re-admitted to hospital because they were not effectively treated the first time. The table below demonstrates a positive impact; for home-based care those going straight home has increased from 93% to 95% and readmissions also

[4] Torrington community cares public, staff, stakeholder engagement report.

reducing from 6.3 to 6.0% despite adding more complex patients to the caseload. The data also shows readmission rates falling to below the baseline rate and also well below the Northern overall rate.

Readmission rates	**Pre- test of change**		**Post- test of change**		**1st 6 months (bedding in period)**		**Results excluding 1st 6 months**	
	Torrington	Northern Locality	Torrington	Northern Locality	Torrington	Northern Locality	Torrington	Northern Locality
Overall readmissions	6.5%	7.2%	6.6%	7.1%	7.4%	7.0%	6.2%	7.2%
readms for those who went straight home	6.3%	7.0%	6.2%	6.8%	6.7%	6.7%	6.0%	6.9%
readms for those who didn't go straight home	9.7%	10.6%	12.1%	10.9%	18.2%	10.8%	9.5%	10.9%
straight home	92.6%	92.7%	94.4%	93.0%	93.6%	92.6%	94.6%	93.1%

[5]

5.8 Despite the positive trends reported by the NHS the patients who are currently treated and now would not be able to be placed in bed-based care at the hospital need to be considered. The Task Group has heard that this is approximately 2 people at any time. Dr Tucker spends considerable amount of time reviewing patient care and experience in her report on Torrington, published in 2014. She concludes:

'The evaluation has concluded that the data has shown that the closure of 10 beds has not had a negative impact on the whole system of health and social care in Devon. The service has been shown to be financially cheaper than the previous model…
…the number were too small, the timescale too short, and the numbers of variables too high to be able to be definitive about cause and effect on the system overall from closing the beds.'

The Task Group has maintained concerns about where the patients would go now they cannot be placed in Torrington. This would either be in a nursing home locally or in a community hospital in Bideford, Holsworthy or South Molton, both of which are more significant distances to travel for relatives. The provision of adequate beds for the minority who will continue to need them is an ongoing issue that has not been resolved by this Task Group.

Concerns over care in Torrington

5.9 The members of the Health and Wellbeing Scrutiny Committee were given seventeen patient stories referring to concerns with their health treatment in North Devon. The Scrutiny Committee does not have powers or a remit to investigate individual complaints. Instead these were passed to the NEW Devon CCG and the Care Quality Commission. However the question over whether these stories provided evidence that since the closure of the hospitals beds patients were disadvantaged, or received a worse standard of care than before.

[5] Information provided to the Task Group by NDHT January 2016

5.10 The response to the Scrutiny Committee from the CCG is reproduced verbatim below, but does not offer evidence to suggest that patients in Torrington are receiving a poorer standard of care.

> *'The 17 patient stories that were presented by campaigners in July 2014 (the stories subsequently presented to Committee members) were investigated thoroughly through the legally-constituted NHS complaints process. If there had been any safeguarding issues, this would have been escalated at the time.*
>
> *Patients named in the stories were contacted and their consent sought for us to look into their experience.*
>
> *Some did not reply and have never replied to us.*
>
> *Four stories were progressed. Two of these were with regards to discharge planning from the acute hospital, one was with regards to domiciliary care and one was relating to a patient story. None were related to the quality of care provided by the health and social care team in Torrington.'*

[6]

5.11 The Scrutiny Committee also raised concerns with the Care Quality Commission, as the independent body to inspect all hospitals. The CQC deemed that no further action was required and in the recent inspection the community services were rated as 'good' overall but the hospitals as 'requires improvement'[7].

Additional services now provided

5.12 In tandem with people who would have been treated in the hospital, now being treated in their own homes, there is a corresponding increase in services provided in Torrington at the community hospital which either weren't provided, or weren't provided as often. The timetable for services is detailed in Appendix 3, with appendix 4 giving a press release in Jan 2016 about new services. The Task Group has been provided with the following as the additional services:

- ⇒ Podiatry - increased 4 days a week
- ⇒ Midwife (most days)
- ⇒ Ultrasound clinic Tuesday all day diagnostic (plan to increase) seen earlier than going to Barnstable
- ⇒ Breast clinic
- ⇒ Drop in- family planning
- ⇒ Services are delivered in partnership with charities, most notably with ageing well and tor-age having a coffee morning weekly. Most transfusions avoid travel journey to North Devon District Hospital (9 people a week)

Financial implications

5.13 One of the key strands of enquiry has been for the Task Group to understand the future sustainability of the changes in Torrington. This is a key piece of evidence in any referral to the secretary of state. Financial viability and longevity is therefore central to the consideration.

5.14 Dr Tucker addresses the financial viability in her analysis of Torrington and comes to the conclusion that:

[6] Letter to health scrutiny from Dr Alison Diamond and Dr John Wormersley 23rd April 2015

[7] CQC inspection report http://www.cqc.org.uk/provider/RBZ 2014

'Overall, the high level financial assessment is used to make the case that the Torrington model is sustainable financially. [8]

This is however based upon macro level finances and is not a detailed investigation of all income vs expenditure.

5.15 The Task Group is very interested to note the Success Regime's analysis of community hospitals,

'The Success Regime has assessed the effectiveness (clinical and cost) of the community hospitals in Devon and early indications are that they are expensive resources which are inefficiently used (i.e. there are other more clinically effective and cost-effective ways of delivering the same care)' [9]

5.16 The Task Group is aware that the model in Torrington was not being used as effectively as possible from evidence in witness sessions. In addition the number of beds, 10, is difficult to comply effectively with policies that prevent lone working. Ten beds actually need two nurses to comply with safe working practices, but that two nurses should actually be looking after sixteen to twenty patients.

5.17 This is based on a high level of stated savings as follows:

	Expenditure	Savings ('000)
Total Inpatient direct costs saved		-£549
Additional community funding	£383	
Savings from reduction in acute admissions		-£80
Net savings		-£246

[10]

5.18 The Task Group has repeatedly asked for a comparison of acute beds against community hospital beds and has been informed that it is not possible to make a direct comparison as the two are not the same. The nearest approximation is below and this is problematic.

		24 hour period
Acute hospital	General medical bed	£150
	ICU	£500
Community hospital		£350 - 450

5.19 The Task Group has struggled to understand why community hospital beds are so expensive. The answer has been that similar resources are required for any medical bed (e.g. nurses), but that where community hospitals tend to operate at inefficient levels. The Task Group has also heard that it is a false comparison to compare community hospital with acute as they offer very different clinical environments.

5.20 The Task Group has heard that considerations of productivity are very important. Where a ward sees many more patients the comparative cost per patient being treated will be higher. In the acute setting the hospital has a much higher patient turn around. There are many reasons for this, including the patient profile in community hospitals where older people tend to need longer periods of recovery and the community hospital average length of stay is approximately 25 days.

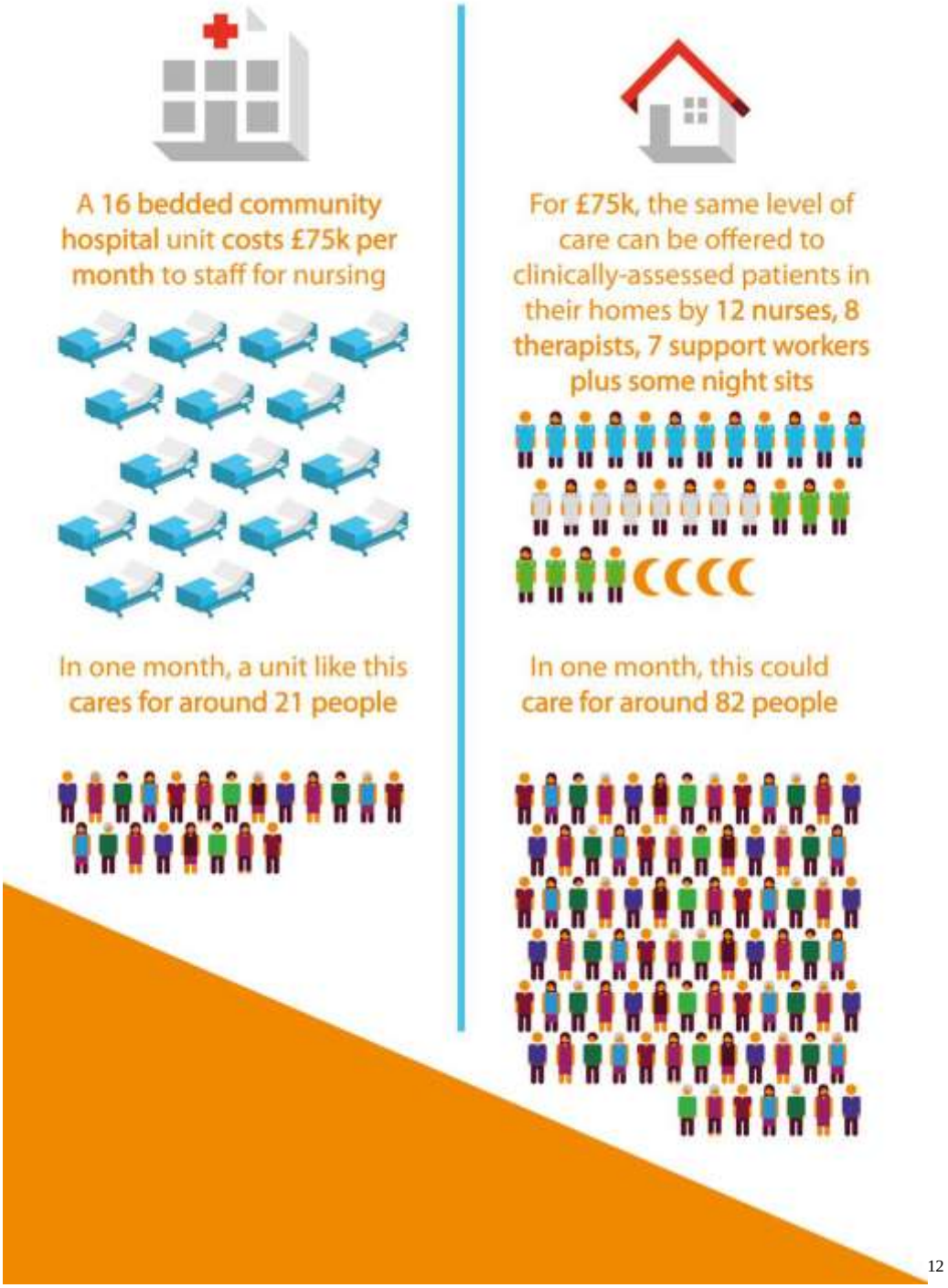
5.21 The Task Group asserts that the comparison between all models of care is required, notwithstanding the clinically different environments. The NHS have submitted evidence demonstrating the cost effectiveness of treating patients at home:

[8] Tucker, H. 'Report to NEW Devon CCG, Torrington Community Cares Independent review of service evaluation' 2014

[9] Information submitted to the Scrutiny Committee by NDHT Jan 2016

[10] Table taken from Dr Tucker's report in Torrington, table modified.

'The model of seeing more patients in their own home is more cost effective because we can care for more patients with the same resource. In a community hospital with 10 beds 90 patients could be seen a year compared to the community where 180 – 200 people can be seen each year. Ratio 3rd cost of providing intermediate care at home compared with in institution'.[11]



[11] NDHT report to Scrutiny Committee September 2015 http://democracy.devon.gov.uk/Data/Health%20&%20Wellbeing%20Scrutiny%20Committee/20150914/Minutes/pdf-PH-15-25.pdf#

[12] Diagram taken from NDHT report to Scrutiny Committee September 2015 http://democracy.devon.gov.uk/Data/Health%20&%20Wellbeing%20Scrutiny%20Committee/20150914/Minutes/pdf-PH-15-25.pdf#

6. Outcomes at Hospital and at Home

6.1 A key criticism of the changes that have taken place in Torrington and other parts of Devon is that there is an unclear evidence base. In particular that the research for people being treated in their own homes rather than in a community hospital does not exist. The Task Group has drawn on a number of sources of evidence as detailed below and can conclusively asset that the evidence base does exist for successful outcomes for people being treated at home.

6.2 This being acknowledged, the evaluation of the most appropriate care setting must be dealt with on a case by case basis with an understanding of all of the evidence and their particular circumstances. Being treated at home will not be suitable for all patients and this may depend upon their medical condition as well as their home circumstances.

6.3 The UK has an ageing and growing population, there is evidence to show that older people are the heaviest users of health and social care services as there is an increase in the number of elderly living with acute and chronic health conditions.

- By 2033 almost 25% of the population will be over 65
- Older people currently account for more than 40% of the NHS budget
- Around 45% of health and community services expenditure is on people over 65.
- The mean age of patients in hospitals is 68,

6.4 In Devon this situation is exacerbated:

- The mean age of patients in Devon hospitals is 72.
- The mean age of patients in Community Hospitals in Devon is 82.
- The mean age of patients in Devon in both Community Hospital and acute hospitals is 74. 6 years older than the national average.[13]

Evidence base: hospital and home

6.5 The Cochrane Institute (a global independent network of researchers, professionals and those interested in health) has conducted a number of investigations that are pertinent to this investigation. Cochrane produces reviews of primary research in human health and health policy, Cochrane is internationally recognised as the highest standard in evidence based healthcare. The UK uses Cochrane reviews to inform the National Institute of Clinical Excellence and The Scottish Intercollegiate Guidelines Network, guidelines. [14]

6.6 When assessing a number of Cochrane studies regarding hospital at home it is evident that there are instances where hospital at home is not suitable for all patients, and needs must be assessed on a case by case basis – predominantly in patient with COPD. However, these Cochrane studies do provide us with clear evidence on the positivity's regarding hospital at home.

6.7 Hospital at home is a service that can avoid the need for hospital admission by providing active treatment by health care professionals in the patient's home for a condition that otherwise would require acute hospital in-patient care, and always

[13] Based on the 2015 Devon County Council Public Health Acuity Audit

[14] Cochrane Collaboration. 'About Us' http://www.cochrane.org/about-us (Accessed: 22/02/2016)

for a limited time period.[15] Out-of-hospital care or 'care closer to home' is a policy initiative that has been on the agenda for around a decade.[16] The Labour Government in 2006 released a white paper outlining care closer to home.[17] There is also an international move to moving care into the community, examples include Norway, Demark, Germany and Canada.[18] Due to technological advances and improvements in clinical practice it is now safe and feasible to do so. [19]

6.8 The Task Group undertook a review of published evidence in this area to understand what independent evidence existed on being treated at home. In reviewing whether it is optimum for patients to be treated in their own home it is necessary to review the standard outcomes as follows: [20]

Domain	Indicators
Preventing people from dying prematurely	Effectiveness of Care
Ensure quality of life for people with long term conditions	
Help people recover	
Positive experience of care	Quality of patient experience
Safe experience and protect from avoidable harm	Patient Safety

6.9 Using this framework the Task Group has reviewed the evidence about hospital treatments vs being treated at home for these outcomes for different conditions. All of these conditions could, at some point be treated in a community hospital, however not all community hospitals in Devon can offer all of these treatments. The data is based on hospital stays in general and is not isolated to community hospitals alone.

6.10 The findings are very interesting (see table across page for detail) and show that being treated at home had a statistically positive impact in the areas of emotional wellbeing, that for patients with co-morbidies fewer patients from hospital at home group were in residential care at a year's follow up. Patients seemed to be happier and more content when treated at home across a number of conditions. Fewer patients were depressed when treated at home. Surprisingly evidence also showed that patients receiving care at home had more care than those in hospital.

6.11 On the negative side, elective surgery showed a swifter return to parental duties for women who had had a hysterectomy before being well enough to do so.

6.12 Overall being treated at home has a measurably positive impact across effectiveness of care, quality of patient experience and patient safety when

[15] Shepperd S, Doll H, Angus RM, Clarke MJ, Iliffe S, Kalra L, Ricauda NA, Wilson AD. Hospital at home admission avoidance. *Cochrane Database of Systematic Review* 2008, Issue 4. Art. No.:CD007491. DOI:10.1002/14651858.CD007491.

[16] Harvey, S. & McMahon, L. "Shifting the balance of health care to local settings – The see-saw report" *The Kings Fund, London,* 2008

[17] Department of Health "Our health, our care, our say: a new direction for community services." Crown Copyright 2006

[18] Royal College of Nursing "Moving care to the community: an international perspective" *RCN Policy and International Department* 2014.

[19] Department of Health "Our health, our care, our say: a new direction for community services." Crown Copyright 2006.pp. 129-130.

[20] Department of Health ' The NHS Outcomes Framework 2015/16' *December 2014*

compared to being treated in hospital. However this assumes that patients are appropriately placed and their needs are well-evaluated. This must include and social care needs being met. Hospital, whether community or district are the option when and only when a person cannot be treated effectively at home.

Outcome Condition	Preventing people from dying	Ensure quality of life for people with long term conditions	Help people to recover	Positive experience of care	Safe experience and protect from avoidable harm
Elective Surgery	No strong data	Insufficient evidence of a difference in clinical complications, functional status, quality of life or psychological well-being between groups.	Between 5-9% of patients allocated to hospital at home were readmitted compare to between 2-10% for inpatient care. The surgeries included: hip replacement, knee replacement and hysterectomy.	Patients believed themselves to be at an advantage being at home but had concerns regarding their carers'. Women having a hysterectomy found they resumed their parental responsibilities before being well enough if allocated to home.	Data relating to patient assessed outcomes was insufficient due draw conclusive comments.
Stroke	Stroke unit care in some cases produces better mortality rates but this isn't significant.	Some evidence to suggest patients at home are more independent but this is not conclusive. Reports of lower anxiety. Less likely to live in residential care is been allocated to hospital at home.	No significant difference in re-admissions rates. Another study found 51/153 patients allocated to hospital at home had to have inpatient care within two weeks	High levels of patient satisfaction at home.	Hospital at home patients reported a better score on the Geriatric Depression Scale.
COPD	Reduction for hospital at home but not significantly different	Little evidence on health related quality of life scores.	Limited data	Most people seem to be satisfied with treatment regardless of site. This is not conclusive. Retrospective reporting found higher preference for hospital at home.	More patients were prescribed an antibiotic at home. Hospital at home is safe for some patients but will require hospital care for exacerbations.
Co-morbidities (many conditions)	No significant difference in mortality rates between groups	Significantly improved scores on functional status and quality of life for those patients at home. No statistical significance for psychological well-being.	Fewer patients from hospital at home group were in residential care at a year's follow up. Staff reported that patients were able to participate in their own rehabilitation.	Increased level of patient satisfaction at home. A study cited that the care they received was timely, frequent, close attention to detail and had good communication. Some reports state ambivalent views.	Three trials found that hospital at home patients were receiving more care.
Dementia	No Data	Elderly patients with dementia who were allocated hospital at home were less likely to live in an institutionalised setting.	Fewer patients at hospital at home group reported problems with sleep, agitation, aggression and feeding.	Significant difference on the geriatric depression scale favouring those at home.	Fewer at home prescribed antipsychotic drugs

7. How should community hospitals be used?

7.1 Following the analysis of the evidence, the question then arises – when is it appropriate to be treated in a community hospital? Throughout the Task Group's investigation it has become clear that community hospitals should be used as much as possible, and that they should provide step-up and step-down care. The next section of this report is dedicated to describing what this should look like and what it looks like at the moment.

7.2 It appears to be a consistent ideology that if someone is sick then being in a hospital is the best place for them. However this is egregious oversimplification. The most important principle is that people need to be treated in the best possible environment with access to the best medical staff. There are occasions when being in a community hospital is not the most appropriate setting for care. Furthermore this decision may appear be at odds to decisions made in the past, as there are changing parameters for optimum health outcomes. The health landscape is not static and with significant advances in technology the conditions that would have once been treated in a particular way may now be treated very differently.

7.3 In a large, rural County such as Devon it is inconceivable that there will not be a significant role in local health care being provided in a community hospital setting:

'Fully functioning well-run community hospitals make a real impact upon acute discharge. People stay for short period before people go home. Invaluable, specific rehab. Let's get people home as quickly as possible. ' Dr Helen Tucker

The use of the hospital setting is likely to change; the Task Group has heard that intense rehab works. Once people get in a community hospital they are likely to be deteriorating. Lengthy stays in an institutionalised situation do not give the best health outcomes.

7.4 Before any service change the NHS needs to co-produce plans for services in local community hospitals. This means undertaking analysis of the following:

- ⇒ The health and social care needs of the local (and wider) community
- ⇒ What services are already provided within the locality (such as hospice)
- ⇒ Access – rurality, remoteness and transport (a key part of an impact assessment)
- ⇒ The capacity of the clinical and care staff to support the services (may require additional staffing, training, support etc.)
- ⇒ Feasibility – factors such as safety, capacity of the building and affordability
- ⇒ Willingness of providers to locate services within the hospital[21]

In future reports to scrutiny the Task Group strongly suggest that these areas are demonstrated by the NHS to the Health and Wellbeing Scrutiny Committee.

7.5 The Task Group would expect to see a number of services being developed and enhanced in community hospitals. These include the following:

Day services. Many of the community hospitals offer a wide and varied range of day treatment services. This includes MIUs, diagnostics and outpatients and effectively provides local and convenient access to core NHS services. services ceased. They are also used by the voluntary sector as a central place for people to access their services

Specialist inpatient care. Some conditions require specialist skills as part of on-going rehabilitation and recovery e.g. patients who have suffered from a stroke.

[21] Dr Helen Tucker in evidence to the scrutiny Task Group 2015

These services tend to be clustered in some hospitals due to the specialist requirements of smaller number of patients.

Complex, multi-morbidity inpatient care. Some elderly people manage independently with a number of medical conditions (called co-morbidities), but can find this difficult if they experience an episode of acute ill-health. For some patients they may need the additional support of bed-based rehabilitation in the first instance to help them return to health and independence.

7.6 The Task Group has heard that the optimum length of stay is on average 11 days, with stays over this length of time increasing the risk of harm through muscle wastage and possible loss of mobility, psychological institutionalization and an increased risk of falls and infections. Although this timeframe is mostly arbitrary as each patient and condition can vary substantially. As demonstrated in the table below the length of time considered medically necessary to stay in hospital has significantly decreased in the past seven years. This shows the change in the treatment approaches to many different conditions.

Optimum length of stay in hospital

The optimum length of stay varies for different conditions but guidance changes rapidly. The days quoted below are indicative only.

Patient Profile	Description	Optimum length of stay 2008	Optimum length of stay 2015
Intensive rehabilitation	Admitted for rehab following a fall or episode of illness	21 days	14 days
Specialist stroke care	Admitted for rehab following stroke	28 days	35 days
Sub-acute care	Admitted for medical or nursing need. Not complex	5 days	3 days
Complex elderly with co-morbidities	A frail elderly patient admitted for medical / nursing / therapy input and diagnosis	42 days	21 days
End of Life care	Admitted for Palliative / End of Life Care	5 days	
Neuro rehabilitation	Admitted for rehab following moderate brain injury	42 days	42 days

There are no standards of occupancy specifically for community hospitals. It is acknowledged that the incidence of infection is lower than an acute hospital, but the average length of stay is longer.

Current use of community hospitals

7.7 To build a picture of the usage of health services in Devon, Public Health Devon undertakes an Acuity Audit. This is a measure of the use of health facilities on a particular day. Audits were carried out by Public Health at the PCT in 2010, 2011 and 2012 then left for a couple of years. One has now been carried out for 2015. The drivers to undertake the audit was to inform winter planning and to identify blockages in system.

7.8 The results show that approximately 40% of people in a community hospital bed have no medical need to be there. This means that they are receiving care that they do not need, and in the worst case scenario the stay itself could be harmful to their health. The acuity Audit 2015 displays worrying trends when compared to previous years.

7.9 Looking at length of stay in hospital beds there were real improvements across the three years from 2010 - 2012 with fewer people being in hospital beds when they had no medical reason to be there. In the latest iteration the trend has reversed and reverted back to 2010 rates. There are several potential reasons for this: 1. Reorganisation of the NHS could have led to a different focus. 2. Providers themselves took eye off the ball. 3. Increase in pressure 2013-2015 we have seen increases in patients and older people. 4. Beds being removed from the system, this is a speculative suggestion. Millions of pounds put into community services, so the removal of beds may not have had an impact.

7.10 The Task Group can take from this data the trends that community hospital beds are not universally being used to the best advantage. This calls for a requirement to use the resources better, not dispose of them.

Future use of community hospitals

7.11 With the change in population needs (long term conditions, cognitive issues) we should be striving to keep people in their own homes as long as possible. If we are going to have community hospitals we need to challenge what is appropriate.

7.12 Community hospitals should not be about people being admitted for lengthy stays, lying for weeks, losing calcium in bones. It has been reported to the task group that in some community hospital wards older people receive very limited care and are lucky to get physiotherapy. Short focused stays should be the only model of care, with admission for a specific reason, not because they are taking up a hospital bed. Aids and adaptations at home need to be provided where necessary.

7.13 To avoid the lengthy and costly dispute of the nature of this investigation and ongoing concern in Torrington, in future the Task Group would like to adopt Dr Helen Tucker's recommendation to undertake a clinical audit of the ward use in community hospitals. This would enable an irrefutable baseline to support any decision regarding change. Dr Tucker quotes the example of "Day of Care" in Scotland, where a clinical audit of every bed in Scotland is being carried out (acute and community hospital) using an Appropriateness Evaluation Tool. The findings from this audit are being used to inform improvements in patient selection, care pathways etc. (Reid et al).

7.14 The Task Group has heard that approximately 44% of people in a community hospital have a cognitive issue, e.g. early dementia and behavioural issues. Community hospitals were not designed for these conditions and appropriate care settings need to be looked at with a view to supporting mental health conditions.

7.15 The Task Group would like to see a consistent approach applied to all community hospitals across Devon to reduce the waiting times and make the best possible use of the existing facilities. [22]

7.16 Discharge and End of life care:

Any future developments with community hospitals must view them as part of the whole system, and not in isolation. Throughout this investigation the Task Group has heard about problems with discharge in North Devon, as identified in the CQC report:

'The rapid discharge process to enable patients who wished to return home quickly at the end of their lives was not effective or well led at a trust level. The trust had recognised that the discharge of patients at the end of their lives was too slow, whilst work was being undertaken improvements in timescale for discharge were not evident' CQC inspection of North Devon Hospital.'[23]

Community hospitals have traditionally played a role in end of life care. The Task Group believes that people should have the choice of where they would like to die. Although evidence suggests that in the majority of cases this is unlikely to be in a community hospital: 'Over 90% people want to stay at home to die.' However for the small percentage of people who do need that support there should still be adequate provision.

End of life care

The patient was diagnosed with cancer, had a stoma fitted. The patient spent a long time in ITU and was becoming 'stir crazy'. The patient was sent home without his medical records. At home his wife was frightened to leave him yet had to go out to collect his prescriptions.

He had carers in three times a week but he didn't want them caring for him. There were no beds available in the nursing home or the community hospitals. The Dr wasn't sympathetic about the lack of help.

The patient had to be taken back to A&E where there was a long wait. His wife had to collect him the next day and was informed his condition was terminal. The blue box was discussed.

A bed vacancy came up at Hatchmoor nursing home. Due to the patients stoma he required a special diet of which the staff were not aware and fed him inappropriate food.

The patient died on 16th January 2015. His wife wants to know if he died alone. End of life care formed a large part of what Torrington Community Hospital offered.

[22] The Good Practice Guide (Care Services Improvement Partnership 2008.)

[23] CQC inspection in North Devon
http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1490.pdf

7.17 Staffing

The Task Group have on-going concerns about recruitment and retention. When Torrington was first highlighted to the Scrutiny Committee, sustainability due to staffing pressures was cited as a reason to temporarily close the beds. Without resolution of the underlying issues with staffing, including low pay, the Task Group fears that this may continue to present a problem.

Staff stories: recruitment and retention

Manager of a local private care firm, manager working over 100 a week hours couldn't get the staff.

There is a belief that there are not enough carers and the carers who serve the area are under a great deal of stress; as a consequence, visits are limited and do not reflect the time patients are expecting, furthermore it is believed that carers are leaving the profession as a direct result of these issues.

Nurses in Torrington have expressed the wish that beds were still available.

[24]

7.18 A final word on home visits. NICE guidelines recommend a home visit last a minimum of 30 minutes. There are circumstances when this visit can be shorter: When the home care worker is known to the patient, the visit is part of a wider package of support and it allows enough time for specific time limited tasks or if it is just to check if someone is safe and well.[25] However the Task Group would expect home visits to be 30 minutes or longer.

8. Conclusion

8.1 The Task Group has undertaken a thorough review of the historical events and current situation in Torrington. The investigation has also encompassed an examination of the national evidence base for the use of community hospitals and care at home.

8.2 The fundamental issue stems from a systemic disconnect where providers operate independently in a position of too little financial support. In this system everyone looses. The loss of beds from community hospitals where commissioners can no longer afford to support the model of care is in danger of focusing upon one aspect of the system at the expense of the whole. From prevention to treatment through to ongoing support and rehabilitation there should be one system that looks after the needs of people as individuals. Only against this backdrop can there be a proper debate about designing and running services that are fit for the population.

8.3 The Task Group has seen that the beds in community hospitals have continued to be used to support people who do not have a medical need to be in hospital. This has prevented the best use of community hospital provision and muddied the waters of the debate.

[24] Information submitted to the Task Group by STITCH

[25] National Institute for Health and Care Excellence 'Home Care: Delivering personal care and practical support for older people living in their own homes.' September 2015. http://www.nice.org.uk/guidance/NG21/chapter/Recommendations

8.4 The Task Group would like to place on record the example of Torrington of how not to approach service change. Identifying that there is a limited need for a service, in this case a bed-based model is not justification for its immediate removal. The Task Group firmly reiterates the sentiment in the Community Hospital Task Group of 2012 that any service change must start with local people. This requirement goes far beyond what is mandated in legislation, and commissioners and providers must work to take the community with them on major change projects.

8.5 The Task Group strongly empathises with the concerns of local people. Health services of the type discussed in this paper are provided to best meet the needs of the local population. It is very serious when local people believe that the statutory agency has not met their needs.

8.6 The observation of the Task Group is that there was a significant breakdown in communication between parts of the community in Torrington and the provider and commissioner in the area. Local people did not wish to lose a much valued local resource and the strength of feeling was underestimated by the NHS. The CCG and the provider have made attempts to resolve the breakdown in relations however once trust was lost it is very difficult to re-establish it.

8.7 The Task Group visited Torrington community hospital and saw the good work of the staff and spoke briefly to patients who were very satisfied with the extended ability to have local blood transfusions. The hub in Torrington does appear to be working well. According to local health practitioners the use of ultrasound has increased and the waiting time has dropped significantly.

8.8 There are people who will still require more intensive support and health care than is possible to offer in their own home. Whilst the numbers of these patients may be small, there still needs to be provision made. Advancements in technology and treatment pathways are to be welcomed but must be applied with discretion as they will not be appropriate in all scenarios. The rurality of Devon and difficulty with staffing and adequate provision of nursing home beds must all factor into any consideration.

8.9 This Task Group began with the question of whether or not the issue should be referred to the secretary of state for Health for a judgement. This Task Group can unequivocally say that the overly bureaucratic system of making a referral has not assisted the Scrutiny Committee in seeing a way to find a positive resolution for the people of Torrington. The Scrutiny legislation has a strong emphasis on local resolution. With the introduction of the Success Regime in Devon there is a different focus. This is to be welcomed, but scrutiny, more than ever, want to see how the views of local people are taken into account when planning changes to health care in Devon.

8.10 The debate about community hospitals is clearly not over. The Task Group remains committed to the maintenance and development of appropriate community settings, especially community hospitals which are much valued local healthcare centres. The Task Group wishes to see resources being spent in the most appropriate way to the benefit of the most people. The appropriate treatment of people takes supremacy over the maintenance of bricks and mortar. It will be an ongoing challenge to the health and wellbeing Scrutiny Committee to continue to manage the need to reflect the views of the public in large scale NHS change whilst retaining oversight of evidence-based policy.

9. Sources of evidence

Witnesses

The Task Group heard testimony from a number of sources and would like to express sincere thanks to the following for their involvement and the information that they have shared as well as to express a desire of continuation of joint work towards the fulfilment of the recommendations in this document.

Organisation	Person	Role
	Peter Copp	Patient Story
	Reverend Morgan	Patient story
	Winnie Hollingsworth	Patient story
	Margaret Dymond	Patient story
STITCH	Margaret Brown Diana Davey Sue Mills Sandra Crawley	Interest Group
Torrington Mayor	Catherine Simmons	Torrington Mayor
Torrington Town Clerk	Michael Tighe	Torrington Town Clerk
HealthWatch	John Rom Miles Sibley	Public Survey
	Virginia Pearson	Director of Public Health
NEW Devon CCG	Kerry Burton Stephen Miller Caroline Dawe	
Northern Devon Healthcare Trust	Chris Bowman Emma Bagwell Katherine Allen Stella Doble	
	Dr Sebastian Mogge	Torrington GP
	Dr Helen Tucker	Independent Report
Hospice Care	Glynis Atherton	Chief Executive of Hospice Care
Devon County Council	Tim Golby	Head of Social Care and Commissioning
North Devon Hospice	Stephen Roberts	CEO
Woodland Vale Care Home	Amanda Moreton	Unit Manager
Torrington Hospital	Kim Brown Nelly Guttmann Nikki Cheshire	Nurse and Communications Lead

The Task Group would also like to place on record their thanks to Geoffrey Cox MP for submitting written evidence to the review.

Finally the Task Group would like to express gratitude to Louise Rayment, Scrutiny Intern for her efforts supporting the research in this Task Group report.

Bibliography

- Bird, S. Priestley, K. 'Appendix 7 Board paper Torrington: Care Closer to Home Rapid Evidence Review' *Public Health Devon* November 2013
- Department of Health 'NHS Outcomes Framework 2015/16' London,
- Department of Health "Our health, our care, our say: a new direction for community services." Crown Copyright 2006
- CQC inspection report in Northern Devon HealthCare Trust 2014 http://www.cqc.org.uk/provider/RBZ
- Harvey, S. & McMahon, L. "Shifting the balance of health care to local settings – The see-saw report" *The Kings Fund, London,* 2008
- Jeppesen E, Brurberg KG, Vist GE, Wedzicha JA, Wright JJ, Greenstone M, Walters JAE. Hospital at home for acute exacerbations of chronic obstructive pulmonary disease. *Cochrane Database of Systematic Reviews* 2012, Issue 5. Art. No.: CD003573.DOI: 10.1002/14651858.CD003573.pub2
- National Institute for Health and Care Excellence 'Home Care: Delivering personal care and practical support for older people living in their own homes.' September 2015. http://www.nice.org.uk/guidance/NG21/chapter/Recommendations
- NDHT report to Scrutiny Committee September 2015 http://democracy.devon.gov.uk/Data/Health%20&%20Wellbeing%20Scrutiny%20Committee/20150914/Minutes/pdf-PH-15-25.pdf#
- Qureshi, H. Patmore, C. Nicholas, E and Barnford, C. *'Outcomes in community care practice Number 5 Outcomes of social care for older people and carers'* Social Policy Research Unit, University of York, 1998)
- Royal College of Nursing "Moving care to the community: an international perspective" *RCN Policy and International Department* 2014.
- Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, Richards S, Martin F, Harris R. Hospital at home early discharge. *Cochrane Database of Systematic Reviews* 2009, Issue 1. Art. No.: CD000356. DOI: 10.1002/14651858.CD000356.pub3
- Shepperd, S. Doll, H. Angus, RM. Clarke, MJ. Iliffe, S. Kalra, L. Ricauda, NG. Wilson, AD. 'Hospital at Home Admission Avoidance Review, 2011. Cochrane Database of systematic Reviews 2008, Issue 4. Art No,: CD007491. DOI: 10.1002/14651858.CD007491
- *Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, Richards S, Martin F, Harris R. Hospital at home early discharge. Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.: CD000356.DOI: 10.1002/14651858.CD000356.pub3.*
- Sheppered S, Wee B, Straus SE. Hospital at home: home based end of life care. *Cochrane Database of systematic Reviews* 2011, Issue 7. Art. No.: CD009231. DOI: 1002/14651858. CD009231.
- Tibaldi V, Isaia G, Scarafiotti C, et al. Hospital at Home for Elderly Patients With Acute Decompensation of Chronic Heart Failure: A Prospective Randomized

Controlled Trial. *Arch Intern Med.* 2009;169(17):1569-1575. doi:10.1001/archinternmed.2009.267

- Tucker, H. '*Report to NEW Devon CCG, Torrington Community Cares Independent review of service evaluation*' 2014
- Health and Social Care Act 2001, sections 7 – 10: http://www.legislation.gov.uk/ukpga/2001/15/contents
- Surrey Downs CCG, 'Community Hospital Services Review Outcome report' September 2015 http://www.surreydownsccg.nhs.uk/media/126378/150918-community-hospital-review-outcome-report-updated-following-feedback-final.pdf
- NDHT report to Scrutiny Committee September 2015 http://democracy.devon.gov.uk/Data/Health%20&%20Wellbeing%20Scrutiny%20Committee/20150914/Minutes/pdf-PH-15-25.pdf#
- National Institute for Health and Care Excellence 'Home Care: Delivering personal care and practical support for older people living in their own homes.' September 2015. http://www.nice.org.uk/guidance/NG21/chapter/Recommendations

10. Task Group Membership

Membership of the Task Group was as follows:

Councillors Richard Westlake (Chairman) Brian Greenslade, Emma Morse, Claire Wright, Andy Boyd and Debo Sellis

11. Contact

For all enquiries about this report or its contents please contact

Camilla de Bernhardt, Camilla.de.bernhardt@devon.gov.uk

Appendix 1: Referral to Secretary of State

January 2015

This paper has been prepared by the scrutiny officer to clarify the process in the event of a referral to the Secretary of State for Health. The information in this document has been summarised from a number of sources which should be consulted in full before a referral is made.

Consultation on Substantial development/ variation

The commissioner of a service has a duty to consult Health Scrutiny when there is a significant change planned. The timescales of the consultation must be clear and published. There is no specific definition on what constitutes substantial variation.

Where a health Scrutiny Committee has been consulted by a relevant NHS body or health service provider on substantial developments or variations, the health scrutiny body has the power to make comments on the proposals by the date (or changed date) notified by the body or provider undertaking the consultation. Having considered the proposals and local evidence, health scrutiny bodies should normally respond in writing to the body undertaking the consultation and when commenting would need to keep within the timescale specified by them.

There are some circumstances where consultation with scrutiny will not be required this is usually on the grounds of risk or safety to patients or staff.

Disagreement on the proposal

Where a health Scrutiny Committee comments include a recommendation and the consulting organisation disagrees with that recommendation, that organisation must notify the health scrutiny body of the disagreement. Both the consulting organisation and the health Scrutiny Committee must take such steps as are reasonably practicable to try to reach agreement. Where NHS England or a clinical commissioning group is acting on behalf of a provider, in accordance with the Regulations, as mentioned above, the health scrutiny body and NHS England or the CCG (as the case may be) must involve the provider in the steps they are taking to try to reach agreement.

Before a referral can be made

Where a health scrutiny body has made a recommendation and the relevant NHS body or health service provider has disagreed with the recommendation, the health scrutiny body may not refer a proposal unless:

- it is satisfied that reasonably practicable steps have been taken to try to reach agreement (with steps taken to involve the provider where NHS England or a CCG is acting on the provider's behalf) but agreement has not been reached within a reasonable time; or
- it is satisfied that the relevant NHS body or health service provider has failed to take reasonably practicable steps to try to reach agreement within a reasonable period.

What are the possible grounds for referral?

Where a health scrutiny body has been consulted by a relevant NHS body or health service provider on a proposed substantial development or variation, it may report to the Secretary of State in writing if:

- It is not satisfied with the adequacy of content of the consultation.
- It is not satisfied that sufficient time has been allowed for consultation.
- It considers that the proposal would not be in the interests of the health service in its area.
- It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

The changes in legislation require a robust evidence base to prove the above points in line with the NHS constitution.

What evidence will be required by the Secretary of State?

When making a referral to the Secretary of State, certain information and evidence must be included. Health scrutiny will be expected to provide very clear evidence-based reasons for any referral to the Secretary of State. Referrals must now include:

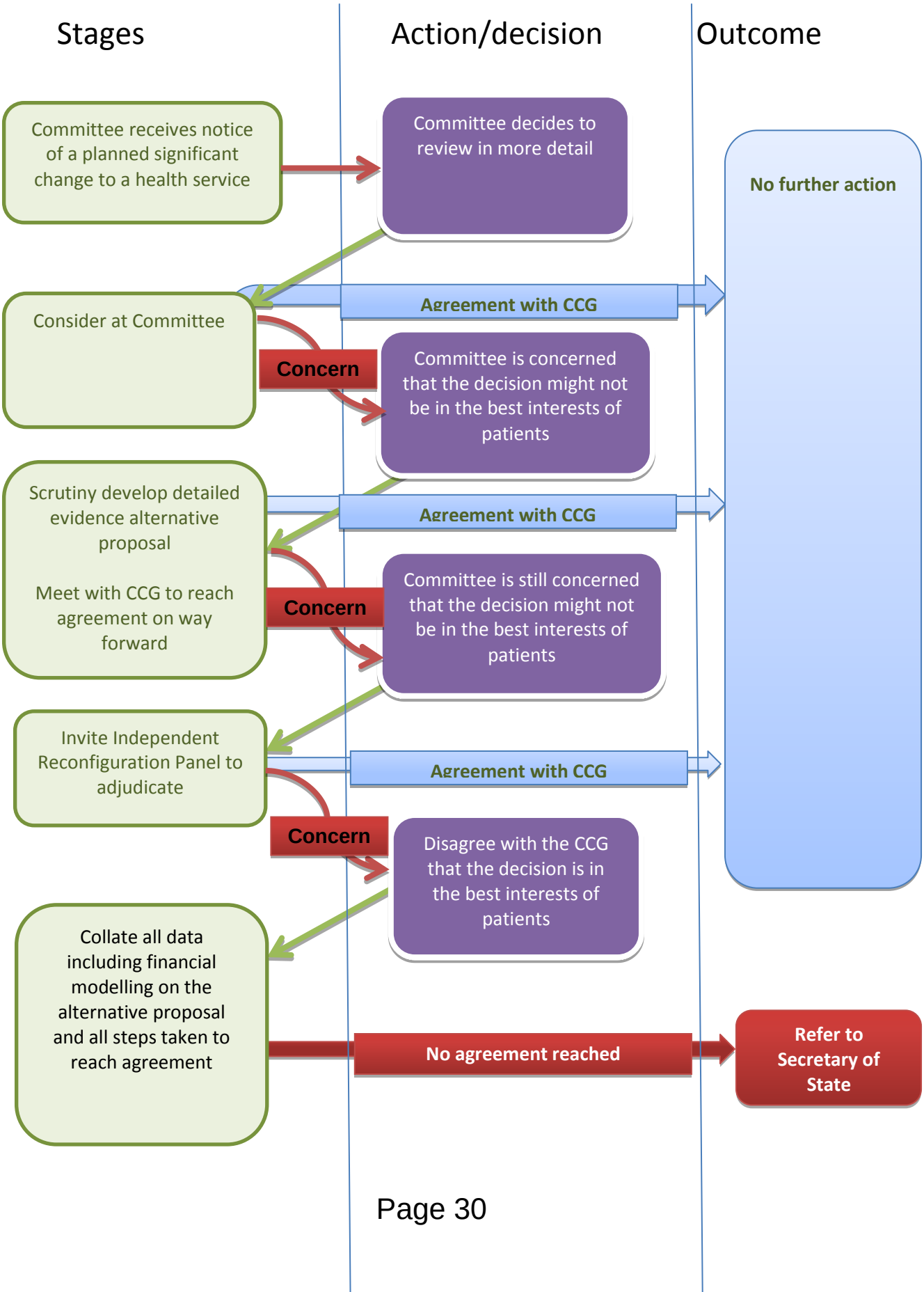
- An explanation of the proposal to which the report relates.
- An explanation of the reasons for making the referral.
- Evidence in support of these reasons.
- Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.
- Where the proposal is referred because there was no consultation for reasons relating to safety or welfare of patients or staff, reasons why the health scrutiny body is not satisfied that the reasons given for lack of consultation are adequate.
- Where the health Scrutiny Committee believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.
- An explanation of any steps that the health Scrutiny Committee has taken to try to reach agreement with the relevant NHS body or health service provider.
- Evidence that the health Scrutiny Committee has complied with the requirements which apply where a recommendation has been made.
- Evidence that the health Scrutiny Committee has complied with the requirements which apply where a recommendation has not been made, or where no comments have been provided on the proposal.

Further information

- Centre for public scrutiny guidance https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf
- Government guidance on consultation principles (2012): https://www.gov.uk/government/publications/consultation-principles-guidance
- Health and Social Care Act 2001, sections 7 – 10: http://www.legislation.gov.uk/ukpga/2001/15/contents
- NHS Constitution http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

Steps to referral

Simplified diagram to represent the stages that Health Overview and Scrutiny needs to go through before an issue can be referred to the Secretary of State.



APPENDIX 2: Torrington Engagement Timeline

July to September 2013	Views of residents and stakeholders gathered through the Torrington Community Cares engagement programme including drop-in sessions.
July to September 2013	Torrington Community Hospital inpatient clinicians redeployed to local vacant posts across the Trust.
8 August 2013	Weekly drop-in meetings commenced to ensure local residents had regular access to NHS representatives to ask questions and air concerns. These meetings were held in Torrington and surrounding villages and continued until 22 November 2013.
August to May 2014	Establishment of the Torrington Oversight Group – representatives of the community overseeing the test of change.
14 Aug 13	Meeting between NHS and Geoffrey Cox, MP, Cllr Margaret Brown, Cllr Harold Martin and Cllr Andy Boyd to discuss engagement process
17 August 2013	Public meeting – cancelled (due to outcome of Geoffrey Cox meeting)
August 13 – April 14 Council meetings and meetings with Councillors and MPs	22 Aug 13 Greater Torrington Town Council 29 Aug 13 Torridge District Council 16 Oct 13 Greater Torrington Town Council 23 Oct 13 Sheepwash Parish Council 5 Nov 13 Frithelstock Parish Council 5 Nov 13 Holsworthy Parish Council 13 Nov 13 Buckland Brewer Parish Council 14 Nov 13 Weare Gifford Parish Council 14 Nov 13 North Devon District Council briefing, Civic Centre 6 March 14 CCG with Cllr Andy Boyd 26 March 14 CCG with meeting with Cllr (Mayor) Harold Martin and Town Clerk Michael Tighe 4 April 2014 MP Geoffrey Cox visits Torrington hospital
12 September 2013	Public meeting

14 September 2013	Public meeting
1 October 2013	Launch of eight-week period of involvement whilst six inpatient beds remained open (as safety net) with staff redeployed from South Molton community hospital.
1 October 2013	Start of six-month evaluation into home-based model of care
October – November 2013	Focused workshop series was launched, to explore in detail the key themes presented by the public
22 November 2013	Due to under-use of the six inpatient beds over the eight weeks they were closed for the remaining four months of the home-based care trial.
31 March 2014	End of the six-month trial of home-based care, inpatient beds remain closed while the final evaluation data was collated.
End of May 2014	The full six months of data was validated and included in the final evaluation report. Then published.
May – June 2014	Continued public engagement carried out through Tour and Talk sessions which were arranged as an opportunity for stakeholders and the public to meet with clinicians and managers from CCG and NDHT to discuss the project in more detail
16 June 2014	Torrington Community Cares six month evaluation and engagement reports are presented to the Devon Health and Wellbeing Scrutiny Committee
21 July 2014	Meeting with Geoffrey cox to discuss next steps and outcome of the test of change
July – August 2014	Model of care and outcomes accepted by CCG and NHDT boards. Final decision delayed by both CCG and NDHT Board decisions to allow time for further public feedback. Four strands to this - 21 days for the community to send in their written concerns or feedback about the care they had received from the community health and social care team serving Great Torrington - A completed dataset to be provided to the Torrington Oversight Group to enable them to make a recommendation to the Boards of NDHT and the CCG'S Northern Locality

	- A final public meeting to discuss the project - The NHS sought an independent and impartial review of the evaluation data by Dr Helen Tucker
7 November 2014	Final public meeting in Torrington
25 November 2014	Final Board meetings – CCG and NDHT
16 January 2015	Torrington Community Cares project outcome presented to the Devon Health and Wellbeing Scrutiny Committee
24 March 2015	Torrington Community Cares project presented to the Devon Health and Wellbeing Scrutiny Committee
18 June 2015	Torrington Community Cares project presented to the Devon Health and Wellbeing Scrutiny Committee
14 September 2015	Torrington Community Cares project presented to the Devon Health and Wellbeing Scrutiny Committee. Scrutiny Task Group established
	Great Torrington Health and Wellbeing Steering Group established and meets monthly to discuss use of the building now inpatients services have ceased. Chaired by Mayor of Torrington and membership from councils, NHS, GP, social care and voluntary sector.

APPENDIX 3: Day Services at the Hub

NEW

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

Torrington Hub Clinic Timetable

Day	Morning	Afternoon
Monday	Orthoptist (monthly) Continence Chiropody Musculo-skeletal physiotherapy Antenatal & postnatal clinics New! Voluntary advice Coming soon!	Orthoptist (monthly) Chiropody Musculo-skeletal physiotherapy Antenatal & postnatal clinics New! Medicines for older people Coming soon! Voluntary advice Coming soon!
Tuesday	Breast clinic (fortnightly) Rheumatology (bi-monthly) Chiropody Musculo-skeletal physiotherapy Antenatal & postnatal clinics New! IV day treatments New! Leg club Coming soon! Voluntary advice Coming soon!	Gynaecology (6 weekly) Chiropody Musculo-skeletal physiotherapy Family planning Antenatal & postnatal clinics New! IV day treatments New! Voluntary advice Coming soon!
Wednesday	Continence Chiropody Musculo-skeletal physiotherapy Antenatal & postnatal clinics New! IV day treatments New! Voluntary advice Coming soon!	Continence Chiropody Musculo-skeletal physiotherapy Falls group Antenatal & postnatal clinics New! IV day treatments New! Voluntary advice Coming soon!
Thursday	Heart failure (monthly) Occupational health (monthly) Chiropody Antenatal & postnatal clinics New! IV day treatments New! Ultrasound Coming soon! Voluntary advice Coming soon!	Chiropody Paediatric physiotherapy (monthly) Antenatal & postnatal clinics New! IV day treatments New! Voluntary advice Coming soon! Ultrasound Coming soon!
Friday	Musculo-skeletal physiotherapy Antenatal & postnatal clinics New! Voluntary advice Coming soon!	Antenatal & postnatal clinics New! Voluntary advice Coming soon!

NB: all clinics are weekly unless indicated otherwise.

Appendix 4

Great Torrington Health and Social Care Steering Group update

January 2016

The Great Torrington Health & Social Care Steering Group, chaired by the Mayor of Great Torrington, met on 12 January and representatives from the Town Council, Northern Devon Healthcare Trust, Devon County Council and a parish representative were present.

Torrington Hospital continues to be put to good use. New audiology clinics began on 13 January meaning Torrington residents will no longer have to travel to NDDH in Barnstaple for these appointments. Instead, an audiologist visits the hospital once a month to carry out hearing tests and fit modern, discreet digital hearing aids, often at the same appointment. The replacement battery service continues unchanged at the Hospital and we are now able to offer a service for hearing aid repairs. At the moment, these will be booked repair appointments, rather than the daily drop in service that will continue to be run at NDDH. The audiology team are assessing the popularity for this service and will increase the number of clinics if this is something people want.

From now on, when patients are booking an audiology appointment they will be given the option to use the audiology clinic at Torrington.

The chemotherapy service is fully utilising the day treatment centre at the hospital. 15 patients a week now have their blood transfusion at Torrington – and these are people who would have previously had to access this service at NDDH.

In 2015 there were three open days at Torrington Hospital. These were really successful and members of the public had the opportunity to see how the different areas within the hospital are being used with new or expanded services and also to find out how people are now being cared for in their homes where appropriate and what support is available to encourage health and wellbeing.

The Northern Devon Healthcare Trust is planning to hold three more in 2016, the first of which – a Parkinson's Awareness Day - taking place on 18th April 2016. This will be an opportunity to find out the latest information about Parkinson's and how people can get support following a diagnosis of this disease. All with an interest in Parkinson's are welcome to attend, whether you've been diagnosed with the condition, or you know someone who has and want to know how you can best support. More information will be available in the next edition of the Crier.

The second and third open days will be about 'Ageing Well' and 'Supporting Carers'.

Volunteers from TorrAGE Ageing Well hope to see you at the hospital on Wednesdays for their Coffee Mornings where you can enjoy 'coffee and a sweet treat' for £1. This is available between 10am and 11.30am and they are also considering the opportunity to offer some computer tablet training during these times. If anyone is interested in this, please give them a call on 01805 622666.

Appendix 5: Letter from Geoffrey Cox MP

Geoffrey Cox Q.C., M.P. for Torridge & West Devon

Our ref: GC/Torrington/ac

30 September 2015

HOUSE OF COMMONS

LONDON SW1A 0AA

Cllr Richard Westlake
Chairman
C/o Scrutiny Team
(re: Torrington Community Hospital)
County Hall
Topsham Road, Exeter
EX2 4QD

Dear Cllr Westlake

Hospital bed closure – Torrington Community Hospital

Thank you very much for your recent letter on behalf of the Health and Wellbeing Scrutiny Committee regarding the above matter.

As you rightly state, I have been involved in the campaign to re-open the community beds in Torrington, in my capacity as the Member of Parliament for Torridge and West Devon, over a period of many months. As part of this campaign I have frequently expressed the view that the approach of the NHS Trust and the CCG, and the manner in which the process of considering the future of Torrington Hospital was implemented, was fundamentally flawed and failed to win the confidence of the local community. In fact, if a textbook example of how not to go about the reform of health services in rural communities were needed, this was it.

Over time I made repeated representations to the two healthcare authorities to this effect, stressing that the local community should have a full and fair opportunity to influence the decision on the future of their community hospital. I also put to them that the evaluation that was carried out by the Trust should have been demonstrated to be accurate and impartial. It was therefore at my request that the decision was taken by the Trust to carry out an independent review of the process in 2014.

It was my firm belief that the whole consultation process should have been full, transparent and meaningful, and that the evidence of local people should have been examined with great care to fully take into account their experiences of the Care Closer to Home pilot in Torrington

Throughout the campaign I organised several meetings with stakeholders; including STITCH, community members, the CCG, and the NHS Trust. The public meeting which was held on 8 November last year in Torrington was one such meeting, the aim of which was to give the local community a fair and full opportunity to make their representations regarding the hospital.

Please reply to the Constituency Office
2 Bridge Chambers, Lower Bridge Street, Bideford, Devon, EX39 2BU.
Tel: 01237 459001 Fax: 01237 459003

Website: geoffreycox.co.uk
Email: tellgeoffrey@geoffreycox.co.uk

It was my hope that that this information would give the decision makers a true understanding of the strength of feeling held by the community regarding the closure, to enable them to make an informed decision.

With reference to the Care Closer to Home scheme that has replaced the beds, I do continue to have some concerns based on the anecdotal evidence provided to me by members of the local community. Regrettably I am not able to pass on such information due to data protection, however, I believe that representatives of STITCH would be able to provide details of cases where it appears that the scheme has not been successful, if this is required.

My concerns about Care Closer to Home extend to the current consultation to close further beds, and it remains my view that to remove any beds without being completely certain that the alternative service is comparable or greater, is ill advised. In light of this I intend to spend a day with the Care Closer to Home team over the coming weeks to see first-hand how the service works.

I hope that the above information is helpful to you. However, if I can help any further then please do not hesitate to contact me.

Yours sincerely,

Geoffrey Cox.

Geoffrey Cox Q.C., M.P.

Please reply to the Constituency Office
2 Bridge Chambers, Lower Bridge Street, Bideford, Devon, EX39 2BU.
Tel: 01237 459001 Fax: 01237 459003

Appendix 6: Press Release to ask for public opinion

People in Torrington asked about healthcare

Posted on: 2 September 2015

A Devon County Council health Task Group is inviting people in the Great Torrington area to let them know their views on healthcare in their community.

NEW Devon CCG and Northern Devon Healthcare NHS Trust introduced a new model of community based care in Torrington in 2013, which focusses on delivering healthcare to people in their own homes.

The pilot aims to improve local people's access to healthcare as doctors, nurses, physiotherapists and others healthcare professionals come to, or closer to people's homes, preventing people travelling any further than necessary to receive the necessary care.

Evidence suggests that, as well as this being a much better way of providing care to patients, it is also more cost effective.

The independent Health and Wellbeing Scrutiny Committee at Devon County Council has been following the pilot, and has had regular updates on progress from NEW Devon CCG and Northern Devon Healthcare NHS Trust.

The Committee agreed in June that its Task Group would seek further evidence from local people who have been receiving healthcare through this new community-based delivery.

They want to hear from people in Torrington and surrounding parishes who have received, or are receiving healthcare at home from district nurses, community matrons, community physiotherapists and occupational therapists or who are now accessing some of the day clinics at the hospital.

The Task Group is asking people to contact them by e-mail via scrutiny@devon.gov.uk, or by post at the address below by 21st September, and ask that people include details of the care they received and when, as well as their contact details in case the Task Group wish to hear more from them.

Scrutiny Team (re: Torrington Community Hospital)
County Hall
Topsham Road
Exeter
EX2 4QD

The Task Group's findings will be reported to the Health and Wellbeing Scrutiny Committee.

- See more at: https://www.devonnewscentre.info/people-in-torrington-asked-about-healthcare/#sthash.f1MykVmd.dpuf

North Devon Gazette Wed 23 Sept 2015 'Adult Social Care

Torrington asked what it thinks of healthcare

Sarah Howells
sarah.howells@archant.co.uk

The deadline has been extended for people in Torrington to make their views on local healthcare known.

Devon County Council's health scrutiny task group is looking at the new model of community care introduced by NEW Devon CCG and Northern Devon Healthcare NHS Trust in 2013.

The pilot scheme saw community hospital beds in the town close, and focused on 'care closer to home'.

DCC's scrutiny task group is looking at whether this is a better way of providing care to patients and whether it is more cost effective.

It wants to hear from people in Torrington who have received or are receiving healthcare at home, or who are now accessing some of the day clinics at the hospital.

Email your comments and contact details by October 8 to scrutiny@devon.gov.uk.

You can also post them to: Scrutiny Team (re: Torrington Community Hospital), County Hall, Topsham Road, Exeter, EX2 4QD.

■ What do you think of healthcare in Torrington? Picture: GUY HARROP

■ **The NHS will be holding an open day at Torrington Community Hospital to find out more about healthcare on Tuesday, 10am-3pm.**

Driving quality, delivering value, improving your services

NHS
South Devon and Torbay Clinical Commissioning Group

PH/16/20
Health and Wellbeing Scrutiny Committee
20 June 2016

Report to Devon Health and Wellbeing Scrutiny Committee

21 June 2016

Community Services Reconfiguration

1 Purpose

This paper advises the Scrutiny Committee on the status of the proposed reconfiguration of community services, recaps on the information provided in our January and April reports, the engagement which has taken place and the planned consultation approach. For completeness it includes details of proposals in Torbay as well as in South Devon.

2 Recommendation

The Scrutiny Committee is asked to note this report; to agree that the work to date forms a basis for public consultation; to confirm that it raises no objections to proceeding to public consultation once final NHS England authorisation has been received; and to reaffirm previous guidance that its preference is to avoid consulting in school holiday periods.

3 Current position

Given the pressures facing the health and social care community in delivering the current model of care, change is inevitable and maintaining the status quo is neither sustainable nor clinically sound.

A model of care has been developed and proposals for consultation were agreed by the Governing Body of South Devon and Torbay Clinical Commissioning Group (CCG) at its meeting on 28 April, subject to NHS England approval.

In summary these proposals, if approved after consultation, will see:

- Increased investment in community based services to provide improved out of hospital services through a clinical hub in each locality and health and wellbeing centres within the main town areas.
- Increased specialist services provided via the new clinical hubs, reducing the need for travel for acute hospital care, including multi-long term condition services.
- Expansion of intermediate care services, both in a person's home and in private sector care home/intermediate care market.

- A reduced need for hospital-based inpatient care and by concentrating community hospital beds on fewer sites, compliance with national safe staffing guidance. This results in the closure of four community hospitals - Dartmouth, Bovey Tracey, Ashburton and Buckfastleigh, Paignton,
- Concentrating MIUs on fewer sites at Totnes, Newton Abbot and (in coastal) Dawlish to provide consistent opening times (8 am to 8pm) with x-ray diagnostic services, resulting in the closure of MIUs in Dartmouth and Ashburton (both currently suspended), Brixham and Paignton.

The proposals agreed by the CCG impact across four of its five localities: Torbay, Paignton and Brixham, Newton Abbot and Moor to Sea. The coastal locality is not part of this process as we consulted here in 2015 and the approved changes in Dawlish and Teignmouth are being implemented.

4 The rationale for change

We face significant increasing challenges in providing health and care services. There are a number of factors we need to take into account in planning how best to meet the needs of our population, both now and in the future, including:

- Increased demand as a result of increasing numbers of older people, many of whom have a number of long-term conditions, many of which are complex.
- Different needs of our rural and urban communities.
- Significant health inequalities and differences in life expectancy between our most deprived and least deprived areas.
- Desire to provide the most clinically effective care and support, irrespective of location
- Importance of aligning physical and mental health services.
- Role and sustainability of community hospitals – given, for example, recruitment difficulties.
- National safe staffing levels for medical beds which require one nurse to eight beds and a minimum of two nurses on duty at any time, which means a minimum bed number of 16 beds.
- Pressure on acute hospital beds and desire to improve community-based out of hospital services.
- Pressure on Accident & Emergency and the need for more effective prevention of avoidable admissions through better utilisation of minor injuries units.
- Increasing effectiveness of preventative and self-care approaches.
- Desirability of closer joint working of health and social care, primary and secondary care, and a stronger partnership approach with the voluntary sector.
- Inconsistent availability of private sector intermediate care beds and associated medical cover.
- Flat or reducing finances, especially when health and social care resources are combined, and the pressures of doing more with less resource.
- Difficulties in recruiting doctors, nurses and other clinical staff.
- Requirements of the national NHS Five Year Forward View and the NHS Mandate.

Clinically there is strong evidence to suggest that:

- Coordinated care in a person's own home, in partnership with health & social care and the voluntary sector, often delivers better outcomes than bed-based hospital care.
- Patients can be admitted to hospital unnecessarily and discharge is often delayed due to a shortage of community services appropriate to meet their needs.
- About a third of people in community hospital beds are medically fit to leave
- The longer an older person remains in a hospital bed, the harder it is for them to regain their independence and return home
- Hospitalisation and bed rest can mean enforced immobilisation and lead to reduction of plasma volume, accelerated bone loss and sensory deprivation. This can be irreversible.
- Older people are more vulnerable to hospital-acquired infections.
- Older people admitted to hospital stay longer and are more likely to be re-admitted.
- Minor injuries unit staff should see at least 7,000 contacts per year to maintain their skills and expertise.

5 Background and engagement

As Scrutiny is aware from previous reports, the CCG in 2013 (in partnership with our acute and community providers, and Devon County Council and Torbay Council) carried out extensive engagement about our community health and social care services.

People told us the most important things to them were:

- Accessibility of services - convenient opening hours, transport and accessible buildings.
- Better communication - between clinician and patient, and between clinicians themselves.
- Continuity of care - to allow relationship-building with clinicians and carers.
- Coordination of care - including joined-up information systems.
- Support to stay at home - with a wide range of services and support.

Over the past six to nine months, we have been engaging with stakeholder groups in Newton Abbot, Dartmouth, Bovey Tracey, Ashburton/ Buckfastleigh as well as in Torquay, Paignton and Brixham, about the significant challenges we face. These meetings have been targeted at those who have relevant knowledge or experience and can make a specific contribution to developing ideas. We have invited interested representatives from local councils, voluntary groups, and the wider health and social care community, as well as those who have expressed an interest in being involved.

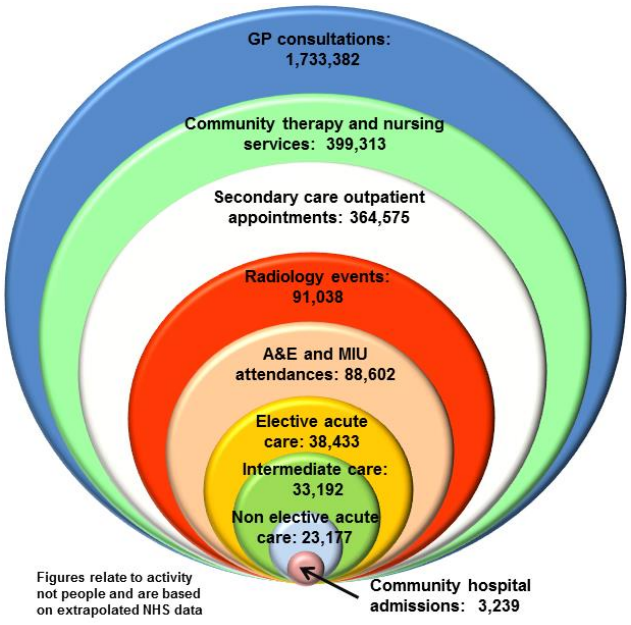
There has also been ongoing engagement with Trust staff in the development of the new model of care. This has consisted of task and finish groups set up to help shape the development of the single point of contact and staff leadership in the development of an enhanced intermediate care model. The strategic development of the care model has been informed by operational managers who have reflected the voices of practitioners and staff working in the community. Locality development groups have been set up for each area and consist of staff membership, local GPs and community representatives. Development days have directly involved staff at all levels to help inform how the principles of the care model will be implemented to best serve the needs of each locality whilst still maintaining a standardised offer to the whole area.

Substantial engagement has also taken place with GP practices by both the Trust and the CCG.

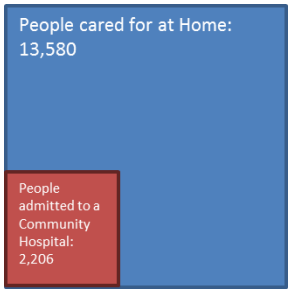
A stakeholder update has kept those attending different meetings up to date with overall discussions, and also an area has been allocated on the CCG website where copies of presentations used at the engagement meetings and copies of the stakeholder updates are available for interested parties to view. www.southdevonandtorbayccg.nhs.uk/community-health-services The CCG would like to place on record its thanks to all those who have participated in the engagement meetings and for their contributions.

During this engagement, our focus has been on finding a sustainable way to deliver responsive, quality care; to build understanding of the underlying issues; and to draw on the expertise of participants to develop a clinically and financially viable model. At these meetings we have discussed in particular:

- The future demographic profiles and their expected impact on the type and range of services required to meet the needs of the population, including the expected increase in long-term conditions.
- The different health pressures across the CCG, with more deprived areas having a younger population with different health needs from people in more affluent areas, where the population tends to be older. The rural impact has also been considered.
- The clinical case for change and clinical best practice.
- The need to provide joined-up health and social care within an ever-tightening financial settlement. Indications from NHS England suggest that the CCG has traditionally received more funds than it has been entitled to under the national formula for allocating health expenditure.
- The costs of delivering services.
- The current levels of extrapolated activity as per the diagram below:



In addition the numbers of people who receive treatment and care to enable them to remain at home is significantly greater than those admitted to a community hospital.



Consideration was also given at these meetings to developing a model of care that could deliver services which would meet people's needs in the future.

In discussing these issues, as well as the clinical case for change, there has been general agreement among most stakeholders, commissioners and providers that the future model of care should:

- Put greater focus on prevention and early intervention.
- Ensure a seamless experience of care through partnership with statutory providers. independent and voluntary sector.
- Make more flexible use of resources.
- Establish a single point of access.
- Manage increasing complexity in the community.
- Care for people as close to home as possible.
- Be sustainable in the future.

There is also however substantial attachment to current services and in particular community hospitals. In towns which have these, there are many people who do not want to see their hospital close and would not accept the argument that many services traditionally provided in a community hospital can today be more effectively provided in people's homes or in another community setting.

In parallel with the engagement discussions, and drawing on the feedback provided, representatives of the CCG, Torbay Council, Devon County Council, Torbay and South Devon NHS Foundation Trust and primary care, including senior clinicians, have considered how best to provide the range of service changes required in discussions at the CCG's Community Services Transformation Group (CSTG) and at its governing body.

The options considered to deliver the model of care have included different configurations of community hospitals, clinical hubs and the services to be provided at local health and wellbeing centres. These options range from radical change (very significant reduction in the number of community beds and a high level of investment in community services) to using our community hospitals in more traditional ways. The proposal put to the CCG governing body as a basis of consultation reflected the option that was considered to provide the most effective and sustainable solution.

Prior to proposals being presented to the CCG governing body on 28 April, a final round of stakeholder engagement meetings was held to advise those who had participated in the process of the draft proposals and to give them an opportunity to comment before they were finalised. We also briefed a number of key stakeholders.

As the detail of the proposals has been reviewed by NHS England as part of its assurance process, we have continued to engage with a range of patients and stakeholders to improve the draft consultation document and refine the questions which we will ask in the consultation.

6 Proposed model of care

The diagram below illustrates the model of care which has been the basis of recent engagement and which is proposed to form the basis of public consultation.

This model of care sees GPs, community health and social care teams and the voluntary sector working together to provide for the vast majority of people's health and wellbeing needs in each of the localities that make up the CCG and Trust population.

To deliver this model of care, resources will be switched from hospital and bed-based care to community-based care.

Whilst we are proposing a new model of care that ensures fair and equal access to services, we recognise that one size will not fit all. From locality to locality, and from town to town, there will be differences in health, demography and geography, as well as for example, variation in the availability of non-statutory services such as residential and nursing care, voluntary sector capacity and access to transport. The proposed model of care will need to reflect these differences so that we deliver more integrated and responsive access to safe, consistent, high-quality care which better meets the needs of local people.

How the model will work

The four key elements to delivering this care model are – locality clinical hubs; local health and wellbeing centres; health and wellbeing teams and intermediate care provision.

Clinical hubs: these are centres which will provide people with better access to a range of medical, clinical and specialist services. They will offer services such as outpatient appointments and specialist conditions clinics. Patients currently travel from a wide geographical footprint to access these specialist services, which are mainly consultant led and have less than 1,000 attendances a year. Specialist services often require more bespoke facilities or equipment and these are more efficiently delivered in clinical hub

settings. There will also be investment in intermediate care and each hub will have access to inpatient beds, MIU and x-ray diagnostic services.

Health and wellbeing centres: these are the locations from where a range of health and wellbeing services, provided by a number of organisations and agencies, are brought together. This will provide easy access in one place to a number of services which support local people. Local health and wellbeing teams will use these centres as a base from which to deliver services to the community, where possible alongside local GPs. Within these centres, the clinical services most frequently used by local people will be provided by professionals who are based locally and work across community sites.

Health and wellbeing teams: these are made up of Trust staff who work most closely with GPs to provide care and support services to meet a wide range of health and wellbeing needs of local people, working closely with other organisations and agencies that contribute to the health and wellbeing of that local population.

This team will oversee arrangements for local **intermediate care** services which cover a range of integrated services, provided for a limited period of time, to people who need extra support and care following a period of ill-health. They are designed to help people recover more quickly following illness or injury, maximising their independence and helping them to resume normal activities as soon as possible. Intermediate care also supports more timely discharge from hospital following an inpatient stay, and helps to avoid unnecessary hospital admissions by supporting people in their local communities, either at home or in another care setting.

In addition, the local health and wellbeing team will coordinate access for local people to the more specialist services provided in the clinical hub, including community hospital inpatient care. Encouraging and signposting local people to appropriately use their nearest minor injury unit will also be a role for the team.

7 Minor injuries units (MIUs)

These provide a local urgent care service in the community, filling a gap between GP services, the 111 service and A&E, and are intended to reduce unnecessary travel to the emergency department for non-life threatening injuries. Consistent, reliable MIU services with excellent facilities mean that patients are more likely to use them. However a lack of awareness, inconsistency in opening times and services provided, including x-ray diagnostic services, have limited their use by local people.

For MIUs to be seen as an alternative to A&E for non-life threatening injuries and they need to be easily accessible; provide a treatment service led by a specialist nurse; be open 12 hours a day, seven days a week; have e-rays; and be delivered in an environment that can best support high quality care. To maintain safety and skills, MIUs should ideally be co-located with community medical beds and out-of-hours GP services.

It is estimated that MIUs need to treat 7,000 patients per annum to ensure the best use of staff and to ensure that they are able to maintain their skills by seeing enough patients with a sufficiently wide range of minor injuries. In South Devon and Torbay, MIUs have seen year-

on-year reductions in attendances and only Newton Abbot MIU has achieved the 7,000 criteria.

To overcome these problems and to ensure that MIUs provide a viable, effective service, we propose to reduce the number to three, located in Newton Abbot and Totnes, as well as (in coastal locality) Dawlish. All three MIUs will open 8 am to 8 pm, seven days a week and will have co-located x-ray diagnostic services.

8 Consultation changes per locality

The way these service improvements impact on each locality is set out below.

> Where reference is made below to **specialist outpatient clinics** that will operate in clinical hubs, these are clinics where patients who currently access these at present, travel from a wider geographical footprint. They are mainly consultant led and are lower in volume, which means they are attended by fewer people (approximately less than 1000 attendances a year). Some non-consultant led clinics such as audiology require more specialist facilities or equipment.
>
> Examples of specialist outpatients include: audiology, cardiology, dermatology, ear, nose and throat, endocrinology, general medicine, general surgery, gynaecology, neurology, orthopaedics, paediatrics, rheumatology, urology.

Community clinics, which will operate in health and wellbeing centres, are attended by a higher volume of people (more than 1000 attendances a year) and are mainly provided by professionals who are based locally and work across community sites. Examples of community clinics include: MSK (Musculoskeletal assessment and treatment, physiotherapy (not gym-based), speech and language therapy, podiatry.

MOOR TO SEA
What will be different?
A new clinical hub will be established at Totnes Community Hospital to serve the wider population that will incorporate community inpatient beds and a range of integrated services provided more locally to reduce the need to travel for specialist care. These will include a new multi long term conditions service, extended x-ray diagnostic services, specialist outpatient clinics and the existing gym-based rehabilitation services and minor injuries unit (MIU). Totnes Community Hospital currently provides 18 beds which will reduce to 16 beds to deliver safer staffing ratios. The MIU facility which is currently open between 8am and 9pm seven days a week will open between 8am and 8pm seven days a week reflecting the times of greatest demand and is consistent with the opening times planned for the MIU in Dawlish and Newton Abbot. X-ray diagnostic services will be available during the opening times of the MIU service. For the local population of Totnes, Dartmouth, Ashburton /Buckfastleigh, local health and

wellbeing teams will be co-located where possible with local GP services. These teams will provide community nursing, physiotherapy, occupational therapy and social care support. Community clinics such as physiotherapy, speech and language therapy and podiatry will be provided as part of the local health and wellbeing centres.

Community inpatient care and more specialist services such as MIU and specialist outpatient clinics for the population of Dartmouth, Ashburton and Buckfastleigh will in future be provided at their nearest clinical hub either in Totnes, Brixham or Newton Abbot.

To deliver more expert care to people in their own homes, we will invest money into providing enhanced intermediate care services that will comprise of more community based staff. These will work in partnership with local care home providers to provide intermediate care beds in local care homes. Providing much more care to people in their own home means that the buildings from which we currently provide inpatient and community services including Dartmouth Community Hospital, Dartmouth NHS Clinic and Ashburton and Buckfastleigh Community Hospital will no longer be required and are therefore proposed to close.

What could services look like and where will they be?

Clinical hub in Totnes (currently Totnes Hospital)

- MIU 8am-8pm
- x-ray diagnostic services
- New multi long term conditions clinic
- Specialist outpatient clinics
- Community beds (16 beds)
- Rehabilitation gym
- Pharmacist

Health and wellbeing centre in Dartmouth (plans are being developed to co-locate with Dartmouth Medical Practice in new premises).

- Health and wellbeing team
- Community clinics
- Rehabilitation gym
- Pharmacy
- Enhanced primary care MIU services

Health and wellbeing centre in Ashburton or Buckfastleigh (options are being explored to co-locate with GPs in either of the local towns or in other facilities).

- Health and wellbeing team
- Community clinics

Health and wellbeing centre in Totnes (options are being explored to co-locate with GPs).

- Health and wellbeing team
- Community clinics

NEWTON ABBOT
What will be different?
A new clinical hub will be established at Newton Abbot Community Hospital to serve the wider population that will incorporate community inpatient beds and a range of integrated services provided more locally to reduce the need to travel for specialist care. These include a new multi long term conditions service, extended x-ray diagnostic services and the existing specialist outpatient clinics, gym-based rehabilitation services and minor injuries unit (MIU). Inpatient services at Newton Abbot Community Hospital will expand from 20 beds to 45 beds plus 15 stroke beds. The MIU facility which is currently open between 8am and 10pm, seven days a week will adopt the same opening hours of other MIU services in Dawlish and Totnes to open between 8am and 8pm seven days a week, reflecting the times of greatest demand and to ensure consistency of access across all MIUs. X-ray diagnostic services will be available during the opening times of the MIU service. For the local population of Newton Abbot and Bovey Tracey, Chudleigh and the surrounding areas the local health and wellbeing teams will be co-located where possible with local GP services. These teams will provide community nursing, physiotherapy, occupational therapy and social care support. Community clinics such as physiotherapy, speech and language therapy and podiatry will be provided as part of the local health and wellbeing centres. We will deliver more expert care to people in their own homes, investing money into providing enhanced intermediate care services that will comprise of more community based staff. These will work in partnership with local care home providers to provide intermediate care beds in local care homes. Providing more care to people in their own home means that the buildings from which we currently provide inpatient and community services including Bovey Tracey Community Hospital will no longer be required and are therefore proposed to close.
What could services look like and where will they be?
Clinical hub in Newton Abbot (currently Newton Abbot Hospital) • MIU 8am -8pm • x-ray diagnostic services • New long term conditions clinic • Specialist outpatient clinics • Community beds (45 beds) • Stroke unit • Rehabilitation gym

- Pharmacist

Health and wellbeing centre in Newton Abbot (as part of plans to co-locate health and wellbeing services with local GP practices)

- Health and wellbeing team
- Community clinics)

Health and Wellbeing Centre for Bovey Tracey and Chudleigh (developing plans to co-locate services with the Bovey Tracey and Chudleigh Practice)

- Health and wellbeing team
- Community clinics

TORQUAY

What will be different?

A new health and wellbeing centre will be developed in the town as part of proposals to co-locate health and wellbeing services incorporating community nurses, physiotherapists, occupational therapists, social care staff and coordination and support staff with local GP practices. The community will have access to a greater range of services including a new multi long term conditions service, enhanced intermediate care services and a health and wellbeing team that works in partnership with local voluntary groups and partner agencies. This community team has been at the forefront of piloting new enhanced services that will continue to deliver high quality services in people's own homes.

A new children's services hub is being planned that will bring many health and care services together to provide holistic support to families and young people.

Castle Circus Health Centre will continue to deliver community clinics and a range of health services and Torbay Hospital will continue to provide specialist services and acute care to the population of Torbay and South Devon.

What could services look like and where will they be?

Health and wellbeing centre (as part of plans to co-locate health and wellbeing services with local GP practices)

- Health and wellbeing team
- Community clinics

Children's services hub
A range of children's services will come together in a new purpose built facility.

PAIGNTON and BRIXHAM
What will be different?
A new clinical hub will be established at Brixham Community Hospital to serve the wider population that will incorporate community inpatient beds and a range of integrated services provided more locally to reduce the need to travel for specialist care. These include a new multi long term conditions service, extended specialist outpatient clinics and gym-based rehabilitation services, with the intention to develop a range of 'one stop shop' services for people with more complex needs and reduce the need to travel for multiple appointments. The current minor injuries unit (MIU) services offered at Paignton and Brixham Community Hospitals are not sustainable in their current form and are proposed to close. People will have the option of visiting a designated GP practice for some MIU services provided locally or attending the MIU in Totnes or Newton Abbot which will operate consistently seven days a week 8am to 8pm, with x-ray diagnostic services. For the population of Brixham and Paignton the local health and wellbeing teams will be co-located where possible with GP services. These teams will provide community nursing, physiotherapy, occupational therapy and social care support. Community clinics such as physiotherapy, speech and language therapy and podiatry will be provided as part of the local health and wellbeing centres. We will deliver more expert care to people directly in their own homes, investing money into providing enhanced intermediate care services that will comprise of more community based staff. They will work in partnership with local care home providers to provide intermediate care beds in local care homes. Providing more care to people in their own home means that the buildings from which we currently provide inpatient and community services including Paignton Community Hospital, Midvale Clinic and Church Street will no longer be required and are therefore proposed to close. Community inpatient care and more specialist services such as specialist outpatient clinics, for example, Audiology, Cardiology and Dermatology for the population of Paignton will in future be provided at their nearest clinical hub either in Brixham, Totnes or Newton Abbot. Staff delivering care directly to people in their own homes will come together in an office base in the King's Ash area providing an integrated team base and easy access to Paignton and Brixham.
What could services look like and where will they be?
Clinical hub in Brixham (currently Brixham Hospital) • New multi long term conditions clinic • Specialist outpatients clinics

- 20 community beds (16 community beds plus 4 flexible use)
- Rehabilitation gym
- Pharmacist

Health and wellbeing centre in Brixham (as part of plans to co-locate health and wellbeing services with local GP practices)

- Health and wellbeing team
- Community clinics

Health and wellbeing centre in Paignton (planned to be developed in Paignton as part of providing fit for purpose accommodation for local GP services)

- Health and wellbeing team
- Community clinics
- Pharmacist
- Enhanced primary care MIU services

9 Intermediate care

An integral part of this care model approach is to stimulate the care home/intermediate care market in South Devon in the same way as it has been developed in Torbay. Notwithstanding the partial role that community hospitals play in this area, it is clear that the current provision does not meet current, let alone future, need.

Until there is certainty as to future demand, it is unlikely that the market will expand. An invitation to express interest will be issued to the private sector so as to facilitate discussions on how best to meet future needs and to explain the model of care and the investment strategy.

Discussions have already taken place with local authority colleagues and with some care home operators. As a result, an initiative is underway to identify the most appropriate model based on a mixture of spot and block purchasing arrangements. It is for example envisaged that procurement of block contracts will shortly be underway in Torbay.

10 Benefits

We want to make these changes to ensure that in the coming months and years, people in South Devon and Torbay will be able to access responsive, high quality care which meets their needs and expectations and is affordable. The changes we propose will provide the following benefits:

- By having a single point of access, we are making it simple and easy for everyone to contact us, regardless of their situation or need. Patients will have easier access to a wider range of community-based services to support wellbeing.

- By focusing on keeping people well and encouraging them to look after themselves better, we will be able to identify and support people at risk of becoming high users of services.
- By intervening early, more people will be able to live independent lives for longer, and will reduce the demand for services.
- People will be more involved in decisions about their care and treatment, working with professionals to identify the best way of meeting their needs.
- Switching resources from hospitals to health and wellbeing teams will enable us to support more people at home or in their community, minimising the need for hospital visits and treatment. In times of crisis, we will be better able to respond quickly.
- By building strong multi agency partnerships with different organisations which support the wellbeing of local people, our service will be greater than the sum of their parts and provide local, seamless care. Professionals will share information enabling patients to avoid having to tell their story to several people.
- For people experiencing multiple long term conditions, their appointments will be organised as close to home as possible in ways which avoid repeat visits and where all relevant specialists can be seen at one appointment.
- The old adage that "the best bed is your own bed" will underpin our efforts to keep people out-of-hospital, enabling them to be treated and to recuperate at home. When an inpatient stay is clinically essential, a hospital bed should always be available and by reducing the number of community hospitals we will ensure that they are properly staffed to deliver quality, safe care.
- MIUs that provide an effective alternative to A&E and can treat a wide range of problems, keeping Torbay's A&E service free to deal with life threatening issues.
- Staff will work in larger teams, have better career prospects and more varied work. Concentrating staff in larger teams will strengthen our ability to deliver care and make them more resilient to issues which have led to temporary closures in the past.

11 Consultation

Subject to final authorisation by NHS England, we propose to consult on this single option as we believe it reflects the best way of meeting the significant challenges that face our health and social care community and which can deliver high quality sustainable health services to meet future demand. We will ask people to comment on our proposal and to suggest any alternative options which they believe are clinically sound, sustainable and affordable.

A comprehensive consultation document, an earlier draft of which has been shared with Scrutiny members, is being finalised. It will be supported by several more detailed documents covering:

- The clinical case for change
- Current use of the health service
- Options and rationale
- Population case for change
- The financial case for change
- Summary of stakeholder feedback

This documentation will be supported by other literature as appropriate, such as an animation, posters and banners displayed in local areas.

We plan to encourage communities to participate in the consultation by holding a series of public meetings, drop in sessions and responding positively to invitations to attend community group meetings. We intend to maximise the use of traditional and social media and hold tweet chats on different aspects of the consultation.

We will look to our partners to support the consultation process via their web and social media outlets, as well as through their regular communication channels.

We will ensure that as much information as possible is made available and we shall deploy all channels available to us as part of our efforts to engage with as many people as possible. Our aim is to target groups who do not usually participate in consultation processes so as to get the widest demographic feedback that we can.

We have asked Healthwatch Devon and Healthwatch Torbay to work together and provide an independent place for all information received through the consultation to be collected, processed and analysed. Online responses and paper responses will go to Healthwatch, which will also provide trained note-takers to record comments made at meetings. A standard questionnaire feedback form (appendix 1) will be used. Healthwatch will provide an independent written report on the feedback and outcome of the consultation for consideration by the CCG's governing body.

Any alternative proposals put forward during the consultation will be thoroughly examined and reviewed to see whether they would provide a clinically sound, sustainable and deliverable model and will be reported to the CCG's governing body.

12 Timetable

Since governing body approved the proposals as a basis for consultation, NHS England and the CCG have been working through the detail of the proposals as part of the NHS assurance process.

We had originally hoped to have completed consultation by the beginning of August, having started in May, but the checking process has taken longer than anticipated. Although this is nearing completion, with no substantial changes to the proposals or approach being made, we are likely to face a choice of starting consultation in the core summer holiday period or delaying it until early September. Starting in the summer holiday period is not ideal and in our view would require a longer consultation.

13 Conclusion

Everyone would recognise that change is never easy, especially when it impacts on well-respected services and requires different ways of accessing services.

In putting forward these proposals the CCG and the Trust have sought to develop a model that takes advantage of modern, evidence-based practices; responds to what people tell us they want; is sustainable and affordable.

A huge amount of effort has been made by a wide range of people to get to this stage and we hope the committee will support the recommendation in section 2 to proceed to public consultation and seek a wide spectrum of views on the draft proposals.

Simon Tapley
Director of Commissioning and Transformation
June 2016

Appendix 1 – Draft consultation questionnaire

Draft Consultation Questionnaire

To formally take part in the consultation

Views expressed at public or community group meetings organised or attended by the CCG will be noted and included by Healthwatch in its consultation report.

Other correspondence and petitions will also be noted by Healthwatch.

Alternative proposals put forward to Healthwatch during the consultation will be thoroughly reviewed and evaluated before being considered by the CCG's Governing Body.

This questionnaire enables you to give your views on a range of issues which underpin the consultation. These will help us to evolve the model of care described in this document and will be registered as part of the consultation.

Paper copies will be available across the South Devon and Torbay area and are available on request by calling [ ] during office hours, emailing sdtccg.consultation@nhs.net, or writing to South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF.

The questions below are presented in sections covering people's preferences for health services and the challenges we face, the proposed new model of care, and the best way we think it can be implemented. Each question provides an opportunity to comment on a number of areas and we would like you to give your views on each.

Draft Consultation Questionnaire

Service preferences and challenges

1. Do you think that the requirements below, which people told us they wanted in 2013 from health services, still apply today?

	Yes	No	Don't know
Accessible services – convenient opening hours, transport and accessible buildings	◯	◯	◯
Better communication – between clinician and patient, and between clinicians themselves	◯	◯	◯
Continuity of care – to allow relationship-building with clinicians and carers	◯	◯	◯
Coordination of care – including joined-up information systems	◯	◯	◯
Support to stay at home – with a wide range of services and support	◯	◯	◯

Is there anything else you would want to see? Please list:

2. Do you agree with the reasons that change is required in relation to:

	Yes	No	Don't know
Establishing better joint working between services?	◯	◯	◯
Looking after the rising number of elderly people, many with long-term conditions?	◯	◯	◯
Tackling differences in life expectancy between affluent and deprived areas?	◯	◯	◯
Providing alternatives to A&E for non-emergency care?	◯	◯	◯
Ensuring that we have enough appropriately experienced staff to look after patients safely?	◯	◯	◯
Making best use of the money available?	◯	◯	◯

3. Do you agree that we should develop more community health services to replace some community hospitals and avoid unnecessary use of hospital beds?

◯ Yes ◯ No ◯ Don't know

New model of care

4. The NHS should support people to keep well and independent for as long as possible by:

	Strongly agree	Agree	Disagree	Strongly disagree
Investing in health promotion activities (eg exercise classes for those with heart and lung disease).	◯	◯	◯	◯
Providing multidisciplinary support nearer to where people live.	◯	◯	◯	◯
Developing more out-of-hospital treatments, especially for old, frail people.	◯	◯	◯	◯
Reducing the number of hospital beds to fund more community services.	◯	◯	◯	◯

5. People should be admitted to hospital when:

	Strongly agree	Agree	Disagree	Strongly disagree
They no longer need nursing or medical care.	◯	◯	◯	◯
They feel lonely or isolated.	◯	◯	◯	◯
Their needs cannot be looked after at home.	◯	◯	◯	◯
Their needs cannot be met by a care home.	◯	◯	◯	◯
Their family feel unable to look after them.	◯	◯	◯	◯

6. When resources are limited, the NHS should prioritise the use of staff and funding to:

	Strongly agree	Agree	Disagree	Strongly disagree
Help keep more people well for longer.	◯	◯	◯	◯
Prioritise the treatment of people with the most complicated health conditions.	◯	◯	◯	◯
Care for people in their own homes or close to where they live.	◯	◯	◯	◯
Keep open expensive-to-run community hospitals that need modernising and offer limited services.	◯	◯	◯	◯

Implementing the model of care

7. When attending outpatient clinics, the most important aspects to you are:

	Strongly agree	Agree	Disagree	Strongly disagree
The time I have to wait for an appointment.	◯	◯	◯	◯
The distance I have to travel.	◯	◯	◯	◯
The specialist that I see.	◯	◯	◯	◯

8. Minor injuries units, which provide treatment for non-life-threatening problems and less serious injuries (such as suspected broken bones and sprains, burns and scalds) should:

	Strongly agree	Agree	Disagree	Strongly disagree
Be open consistent hours, seven days a week.	◯	◯	◯	◯
Have x-ray diagnostic services.	◯	◯	◯	◯
Be staffed by specialists experienced in dealing with minor injuries.	◯	◯	◯	◯
Be easily reached and have good car parking.	◯	◯	◯	◯
Operate different hours in different locations.	◯	◯	◯	◯
Offer different services in different locations.	◯	◯	◯	◯

9. If the choice is between:

- Using resources to keep open community hospitals which look after small numbers of people from across the CCG area

Or

- Using these resources to expand community health services by recruiting more trained nurses and therapists to help keep people healthier, out of hospital and supported closer to their homes

Do you on balance agree that it is better to do the latter?

◯ Yes ◯ No

10. If your answer to Question 9 is 'yes', please respond to the statements below:

	Yes	No	Don't know
Close Ashburton and Buckfastleigh Hospital	◯	◯	◯

Please explain the reason for your decision:

	Yes	No	Don't know
Close Bovey Tracey Hospital	◯	◯	◯

Please explain the reason for your decision:

	Yes	No	Don't know
Close Dartmouth Hospital	◯	◯	◯

Please explain the reason for your decision:

	Yes	No	Don't know
Close Paignton Hospital	◯	◯	◯

Please explain the reason for your decision:

11. People sometimes need nursing with extra support and care, following a period of ill health, to help them recover and regain their independence. If similar levels of care and support can be provided, this should be delivered:

	Strongly agree	Agree	Disagree	Strongly disagree
In a person's own home	◯	◯	◯	◯
In a community hospital	◯	◯	◯	◯
In a care home near to a person's home	◯	◯	◯	◯

12. If you want to comment generally on the proposals set out in this document or have any alternative ideas to put forward for consideration which meet the future needs of our population and the challenges described in this document, please set out below (or in an additional submission):

13. If you are responding on behalf of an organisation, please tell us what type:

- ◯ NHS provider organisation
- ◯ Patient representative organisation
- ◯ Third sector provider
- ◯ County or district council
- ◯ League of Friends or equivalent
- ◯ Town council or parish council
- ◯ Independent healthcare provider
- ◯ Other - please state:

Other information

To help put this information into context and ensure we are attracting feedback from across the South Devon and Torbay CCG area please complete the following questions:

14. Postcode (so that we will know if we are getting feedback from across the area)

- ◯ No fixed abode
- ◯ Traveller
- ◯ Postcode

15. Age

- ◯ Under 16
- ◯ 16-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65-74
- ◯ 75-84
- ◯ Over 85

16. Disability (do you consider yourself to have a disability?)

- ◯ Yes
- ◯ No

17. Do you have one or more long-term health conditions?

- ◯ Yes
- ◯ No

18. Gender

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Prefer not to say

19. Sexuality

- ◯ Heterosexual
- ◯ Gay
- ◯ Lesbian
- ◯ Bi-sexual
- ◯ Prefer not to say

20. Ethnic group - which category best describes your ethnicity? Please tick the appropriate box to indicate your ethnic background:

- ◯ White: British
- ◯ White: Irish
- ◯ White: Other
- ◯ Black/Black British: Caribbean
- ◯ Black/Black British: African
- ◯ Black/Black British: Other
- ◯ Mixed: White & Black Caribbean
- ◯ Mixed: White & Black Africa
- ◯ Mixed: White & Asian
- ◯ Mixed: Other
- ◯ Chinese
- ◯ Asian/Asian British: Indian
- ◯ Asian/Asian British: Pakistani
- ◯ Asian/Asian British: Bangladeshi
- ◯ Asian/Asian British: Other
- ◯ Other ethic group

Thank you very much for completing this questionnaire and for formally contributing to this consultation.

PH/16/19
Health and Wellbeing Scrutiny Committee
20 June 2016

Community Services in Northern Devon - update

REPORT TO: Devon Health and Wellbeing Scrutiny Committee

DATE: 20 June 2016

PRESENTED BY: Stella Doble
Assistant Director Health and Social Care
Northern Devon Healthcare NHS Trust

1. Contents

In January 2016, Northern Devon Healthcare Trust (NDHT) provided an update to the Committee on the status of community services in Northern Devon over the winter period, following the outcome of the public consultation: safe and effective care within our budget. This saw a reduction of community hospital inpatient beds from 75 to 40, in line with commissioning intentions.

It was agreed that NDHT would provide a further update in March in response to the additional questions that were raised at the January meeting. Unfortunately the Trust

was unable to provide a report at that time and the committee asked for an updated report to be presented on 20 June 2016.

The Committee requested that "a report be made to the next meeting on the transition from community hospital care provisions to community services and how well it was operating to include: financial and clinical impacts, analysis of outcomes and satisfaction survey information of patient experiences."

We have prepared a report which therefore contains the following information:

1. Further update on winter performance
2. Financial impact of the transition from hospital to community
3. The impact on patients in terms of number of patients cared for in the community, number of admissions to the acute hospital and other community hospitals
4. The impact on staff: detail of the redeployment of staff from the community hospital (Bideford)
5. Patient satisfaction with the community model of care

2. Winter performance

As the Committee will be aware, the Northern Devon Healthcare Trust has been pursuing an 'out of hospital' strategy for many years as the evidence shows that care delivered in or close to people's homes provides better, more person-centred care to patients which maintains their wellbeing and independence and delivers more system resilience in times of high demand for services.

Compared to 2014/15, last winter, the Trust operated with 25 fewer community beds and 22 fewer acute beds. We are pleased to report that over the challenging winter period the system coped extremely well in Northern Devon, particularly when compared to systems which had increased their beds. Despite the ongoing high demand for our services and pressure in the wider health and social care system, NDHT experienced fewer and shorter periods of escalation, i.e. was never in 'black' and managed to recover from 'red' within a few hours in the majority of times. Our NDDH A&E performance was recently ranked as the top-performing in the country in terms of the 4 hour wait.

Having intensively analysed all of the available performance metrics and quality indicators it is our belief that we were able to provide better and more consistent safe and high quality services despite our winter pressures because we changed the way we delivered care last winter – shifting it out of hospital and closer to people's homes.

The closure of community hospital beds allowed us to focus more of our highly skilled and professional nursing, doctor and therapist resources into the community

to support patients safely avoid unncessary admissions to hospital, as well as ensuring that our ward teams at NDDH have all the support they need to help people back to their homes without delay.

The Trust is able to provide assurance to the committee that we have dealt with periods of escalation very well and de-escalated within hours because we have learnt how to work as a system to cope in periods of high demand. Across GPs, mental health, the ambulance service, social care, our hospitals, community teams and the voluntary sector, we all play a part in making sure the system meets demand and delivers consistent quality services.

3. The financial impact

It is a far more clinically-effective and cost-efficient model of care to deliver more care in people's homes as opposed to small community hospitals. This is because resource is invested into our skilled and mobile workforce not building maintenance, utilities and rates. Nurses and therapists can care for more almost four times as many people with the same resource (please see Appendix A) with the added benefit that patients receive this care in their own familiar surroundings.

As the committee will be aware, the consultation was entitled safe and effective care within our budget and the Trust was explicit that this budget had reduced in 2015/16 by £11 million, £5 million of which was allocated to our community contract. There were many other efficiencies that we made to our services in 2015/16 but regrettably we still ended the financial year with a £4.7m deficit.

Bideford Willow Ward was a 16-bedded ward which cost approximately £75k per month to run and cared for 21 inpatients a month (on average).

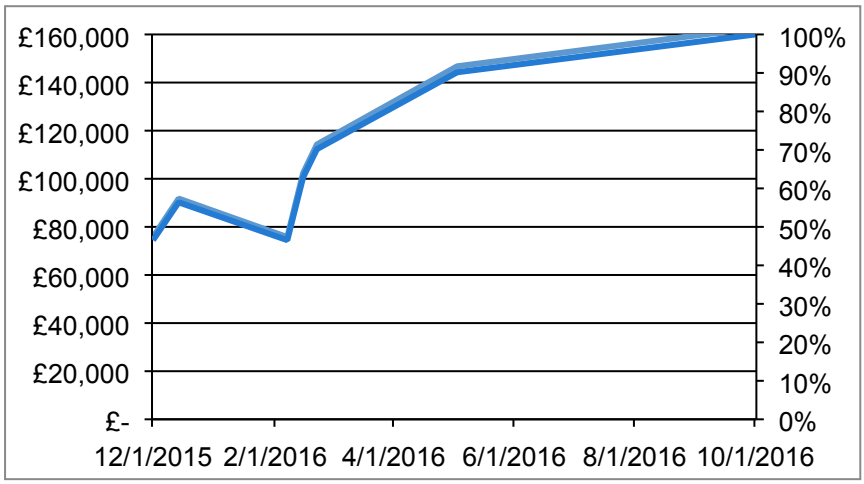
When this ward was closed, the Trust used a tried and tested formula, based on our experiences of other ward closures, to allocate a budget (£160,000) which was moved into the Bideford community team to give it the capacity to care for the extra patients (approx. 21) per month who would have been admitted to Willow Ward. This £160,000 per year is a recurring uplift to the staffing budget and has enabled the increase in the number of community nurses, physio and occupational therapists and support workers in the community team in that area.

4. The impact on staff

The table below shows the investment in the community teams to replace the hospital beds.

It has taken a number of months to recruit all the staff needed and to date we have spent £150,000 of this additional £160,000.

It is anticipated that the full cohort of staff will be operational by October 2016.



This graph shows the utilisation of the additional budget for staffing the community team

Having safely replaced community inpatient beds with out of hospital community services on many occasions, our senior clinical and operational teams keep the quality of care under constant review for the first few months to check that the additional resource that was placed into the community team is a) in the right place and b) in the right configuration (i.e. grade or profession of staff). This continual oversight led to a decision in March 2016 to increase the budget by £75,000.

The Trust is operating within a very challenging clinical employment marketplace and is very focused on supporting our staff during service change. At the beginning of each financial year we meet as many staff as we possibly can to brief them on the next year's challenge, clinical direction of travel and budget and ask for their views on how the Trust can best meet this challenge. We firmly believe that this front-line involvement in the Trust's plans correlates to our excellent staff survey results which, for the last two years, has put NDHT as one of the best NHS Trusts to work for. This is interesting given the degree of service change we have delivered.

In addition to their involvement in the safe and effective care within our budget consultation, we also conducted a full employment consultation process with affected staff, supported by the Trades Unions, which enabled staff to consider new opportunities within the Trust.

This approach ensured there were no redundancies of valued members of staff and all those Bideford clinical and non-registered employees that wanted to stay with the Trust were redeployed across the organisation, primarily within the local community health and social care team.

20 members of staff were affected in total:

Staff group	Number of staff	Transferred to :
Registered Nurses	4	NDDH - acute wards/Pathfinder Team/ASU
Registered Nurses	3	Community nursing team - Bideford
Registered Nurses	1	Other community hospital wards
Health Care Assistants	3	NDDH – acute wards/day surgery
Health Care Assistants	4	Other community hospital wards
Health Care Assistants	1	Community team - Bideford
Health Care Assistants	1	MIU
Health Care Assistants	2	Resigned
Ward Clerk A&C	1	Bideford community team

As we deliver more and more care outside of hospitals, the Northern Devon Healthcare Trust has developed a comprehensive support package to enable staff previously employed in a community hospital inpatient setting to gain the confidence and transferrable skills to work in an acute or community setting.

5. The impact on patients

Impact on patients of existing model of care

As part of the consultation there was a full Quality Impact Assessment (QIA) which included the impact on patients of the existing provision of care within community hospitals:

- The average length of stay (LoS) in a community hospital is approximately 21 days. 70% of patients are have already been in the acute hospital and have had an overall stay (“superspell”) over this amount.
- It is nationally recognised that an inpatient stay greater than 11 days places the patient at increased risk of incurring a complication e.g. UTI, pressure damage, fall or medication error.
- It is also known that an increased LoS reduces the ability of the patient to return to the previous level of independence and well-being.
- We know that 40% of patients discharged from community hospitals are discharged to a care home as they have lost their independence and are no longer able to cope at home.

- Devon County Council's Public Health team undertook an acuity audit in May 2015 of each acute and community hospital within the CCG's boundary. In North and East it confirmed that on any given day between 30% and 47% of patients in our community hospitals could, and should, be cared for in a different way out of hospital, even if they had originally required admission to hospital.
- There is widespread evidence that patients have better outcomes and regain independence quicker in their own homes following illness or injury, where that is safe to do so.
- Subsequently the SR case for change confirms that on any given day across Devon over 500 people are in hospital uncessarily, i.e. they are ready to be discharged.

Impact on patients of change to new model of care

Inpatient beds closed in Ilfracombe in September 2014 and in Bideford on 10 November 2015 and were replaced with enhanced community health and social care teams who deliver care and rehabilitation for people in their own homes.

For Ilfracombe, the closure of beds 'displaced' 9 patients over an 18 month period (e.g. 0.5 of a patient per month went to another hospital)

For Bideford, the closure of beds 'displaced' 9 patients over the first 6 month period (e.g.2 patients per month went to another hospital).

Prior to the beds closing, at any one time, our community teams had a caseload of approx. 600-700 patients in the Bideford area (also covers Northam) and 600-700 patients in the Ilfracombe area (also covers Braunton and Lynton).

Closure of the beds has increased the caseload of the community teams by approx.104 patients in Bideford and 7 patients in Ilfracombe.

The following data compares Ilfracombe and Bideford; however it must be pointed out that it is very early to draw concrete conclusions from the Bideford data and also we are not comparing like for like time periods.

Despite this, we have confidence in this new model of care in Bideford because our experiences in Torrington, Crediton, Axminster and Ilfracombe show that a period of "bedding down" is needed, and we know that, as the full complement of staff is achieved (as per the comment above) the statistics will improve.

In addition, we are closely tracking these patients through the system, so we are confident that their needs are being met.

Population	**Bideford**		**Ilfracombe**	
Period	6 months	Rest of Northern benchmark	18 months	Rest of Northern benchmark

Comparator	Same 6 calendar months from previous 2 years		Previous 18 months	
1. NDDH admissions	4%	5%	-1%	3%
2. NDDH bed-days	16%	1%	17%	11%
3. NDDH length of stay	12%	-4%	18%	8%
4. Admissions to South Molton CH	+7	n/a	+17	n/a
5. Admissions to Holsworthy CH	+2	n/a	-8	n/a
6. CH admissions overall	-75%	3%	-84%	1%
7. CH bed-days overall	-67%	-7%	-77%	4%
8. CH LOS overall	32%	-10%	44%	3%
9. Attendances to NDHT MIUs + NDDH A&E	-2%	2%	-3%	2%
10. Community visits	5%	2%	4%	2%
11. Community clinical face-to-face time	5%	4%	16%	4%
12. Community mean visit length	0%	2%	11%	2%
13. Community urgent visits	41%	30%	63%	30%
14. Community urgent clinical face-to-face time	38%	35%	74%	35%
15. Community urgent mean visit length	-2%	4%	7%	4%

Narrative on the data in the table

Both Ilfracombe and Bideford have seen increased home visits but the length of visit in Bideford has remained roughly static whilst the length of visit in Ilfracombe has greatly increased (+11%) (line 12). This therefore means that there has been an increase in patient-facing time of 5% for Bideford and 16% for Ilfracombe (lines 10 to 12 in the table).

A&E attendances have been slightly reduced for both areas (-2% in Bideford and -3% in Ilfracombe), whereas in the general population, attendances have risen by 2%.

This patient need for ‘urgent’ care is now being met by the increase in rapid response from the community team, only made possible by the increase in resource in the community health and social care team (line 15).

As expected, both Bideford and Ilfracombe patients admitted to NDDH are seeing a small increase to their average length of stay, but Ilfracombe has seen reduced admissions to the acute hospital (only -1%) whilst Bideford has experienced an increase (+4%). The same trend happened in Torrington and we expect this to come down to similar levels over the next few months as the community team reaches full capacity.

There has been a large reduction in community hospital admissions from both catchment areas. Both South Molton and Holsworthy hospital accept admissions from patients across North Devon and Torridge. South Molton saw an average of

one extra patient a month from Ilfracombe and one extra patient every two months from Bideford. There was no increase in admissions to Holsworthy from Bideford, whilst admissions from Ilfracombe to Holsworthy have dried up entirely. If there was a significant medical need for Community Hospital beds, we would have seen far more admissions to both Holsworthy and SM community hospitals from Bideford and Ilfracombe patients.

Overall whilst we would like to see more data on Bideford before drawing conclusions with confidence, we are reassured that the clinical adverse impact on patients is low in both areas, which can be balanced against the evidence of improved community team working and reduced hospital admissions.

6. Patient satisfaction

The Friends and Family Test (FFT) is used across all services provided by the NHS and asks people if they would recommend the services they have used. The Northern Devon Healthcare Trust also asks patients for their 'free text' comments on the service and if the service could have been improved.

When combined with supplementary follow-up question, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting excellent patient experience .

FFT cards are left with patients in their homes and the patient posts the card back to the Trust (using freepost). Appendix B shows the patient experience data from the community teams in the period from November 2015 to March 2016 (latest data available).

As can be seen, the community teams have received an overwhelmingly positive response through the FFT:

- Community nursing teams: teams achieved a 100% positive "would recommend" score except for a 97% score in Nov 2015 (137 responses)
- Community therapy teams: achieved an average "would recommend" score of 98.72% (256 forms received)

Comments received via 'free text' include:
Nursing:

- The nurses are excellent in knowledge, skill, and attitude. They are concerned for my father's needs and for mine as a carer. (Barnstaple - Oct-15)
- Nurses were kind, helpful & efficient. It's a help to not have to travel to Barnstaple to clinic. (Ilfracombe - Oct-15)
- The nurses and response team are always there for me and are a warm and friendly team. (Lynton - Oct-15)

- All the nurses were kind, cheerful & efficient & always concerned for one's welfare. Their visits were always welcome. (Holsworthy / Torrington - Jan-16)
- Very pleased with care shown from all DNs [district nurses]. (Bideford - Jan-16)
- The staff are reliable and very professional. (Bideford - Jan-16)
- I have received exceptional service. (Lynton - Feb-16)
- Good, friendly service at [age]. A friendly face & good care and help is just wonderful. Thank you for all the help. (Bideford - Mar-16)
- Because they are very professional and caring nurses, always time for a chat and always smiling. (Ilfracombe - Mar-16)

Therapy:

- I couldn't have had better care from start to finish. (Bideford - Oct-15)
- Experience of close personal attention by staff when in all the exercise routine - excellent. (Bideford - Oct-15)
- Courteous, polite. Explained everything clearly. (Bideford - Oct-15)
- D. your physiotherapist was so professional, polite, caring. A good experience. His advice is continuing to help me. (Bideford - Nov-15)
- Nothing by them was anything but positive and my rehabilitation was on-going and speedy due to their professionalism. (Barnstaple - Jan-16)
- Very helpful and lovely people, very caring and gave me confidence. (Ilfracombe - Jan-16)
- The care I received following my fall was far better than I expected and I am grateful to everyone involved. Thank you all very much. (Bideford - Feb-16)
- Everyone was extremely efficient as well as being compassionate, friendly and helpful and caring. (Bideford - Mar-16)
- As they took time to listen to my needs and help and patience they gave to me. (Ilfracombe - Mar-16)

Complaints

An analysis of complaints data shows that in the period from 1 November to 26 May 2016 there was one issue raised with our PALS team relating to our Northern Community health and social care teams (those delivering care in people's homes). This relates to a gentleman who was discharged from RD&E and informed that an Occupational Therapist would visit but they cancelled the appointment on 3 occasions. This complaint was fully investigated at the time, the community nurse team leader called the patient to apologise and an appointment was made for the following week. The patient was satisfied with this resolution.

The table below compares the complaints received from patients regarding their experience of community hospitals over the same period (1 Nov-26 May)

Complaints, concerns and enquiries to Patient Advice and Liaison Service (PALS):

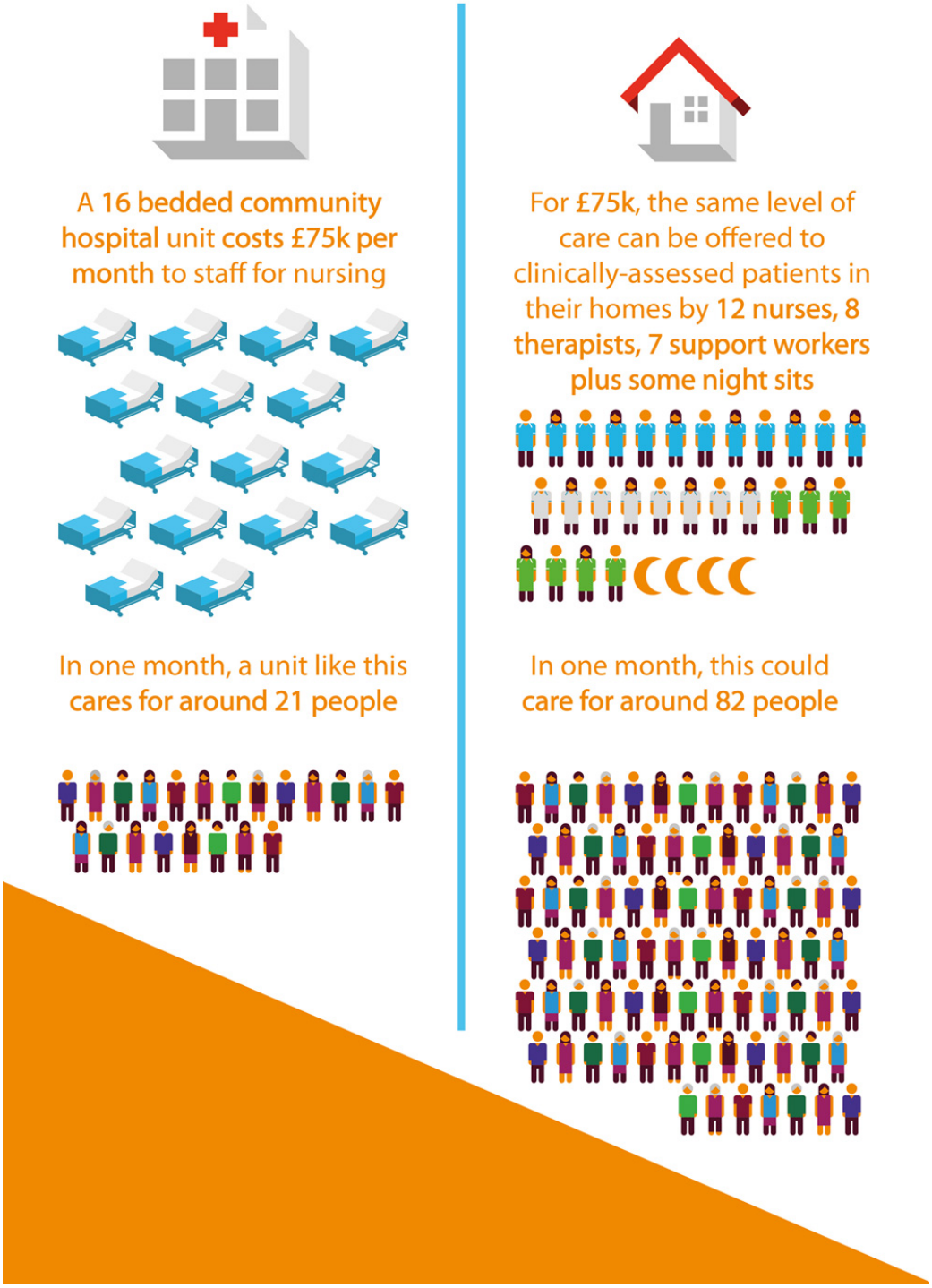
Team	Complaints	Concerns	Contact with PALS

Bideford Community Hospital	3	1	14
South Molton Community Hospital	1	7	1
Holsworthy Community Hospital	0	1	3
Northern Community Nursing Team	0	0	1

7. Conclusion

Our commissioners, regulators and the Northern Devon Healthcare Trust Board regularly review the quality, clinical and financial performance of all our services. In our last CQC inspection, our community services not classed as "good" and the inspectors' comments indicated they were close to "outstanding". The Trust is confident that the level of care for people who are being looked after in their own homes is as good as or better than the care they would have received in hospital. Patient satisfaction levels are high and there has been an overall reduction in harm events.

8. Appendix A – comparison of community hospital vs community teams



9. Appendix B – Patient experience survey results – northern community – Oct-15 to Mar-16

Summary

During the period Oct-15 to Mar-16 a positive set of patient experience results was returned from the northern community nursing/therapy teams and from the inpatient wards at Holsworthy and South Molton community hospitals.

1. Community nursing teams (north). The results are based on 137 patient experience survey forms returned during the period. The composite FFT score achieved was 100% across the teams for all months with the exception of Nov-15 (97%). The other survey questions consistently achieved the target score with the exception of *Q1. Were you offered a morning or afternoon appointment for us to visit you in your home?* which dipped below target in Feb-16 and Mar-16 and *Q2. Were you contacted in advance if we were unable to keep an appointment?* which dipped below target in Jan-16

   The nature of the majority of patient comments received was complimentary and some examples of these are listed in the detailed information below.

   Of the 137 patient survey forms returned, there was a total of 26 negative mentions / suggestions for improvement of which those receiving more than one or two mentions (accounting for 50%) were the patient perception for the requirement for more community nursing staff (10) and the patient perception that the nurses had too much paperwork to complete (3).

2. Community therapy teams (north). The results are based on 252 patient experience survey forms returned during the period. The composite FFT score achieved was 100% across the teams for all months with the exception of Nov-15 (93%) and Mar-16 (97.7%). The other survey questions consistently achieved the target score with the exception of *Q1. Were you given a choice about when your first appointment would be?* which dipped below target in three of the six months.

   The nature of the majority of patient comments received was complimentary and some examples of these are listed in the detailed information below.

   Of the 252 patient survey forms returned, there was a total of 24 negative mentions / suggestions for improvement of which those receiving more than one or two mentions (accounting for 58.3% of the total) were the delay in the start of the treatment (6), delay between appointments (4) and the need felt for more follow-up visits (4).

3. Holsworthy community hospital. The FFT score achieved was 100% for the period Nov-15 to Feb-16. No data was returned in Oct-15 and Mar-16.

4. South Molton community hospital. The FFT score achieved was 88.9% in Oct-15 and 100% for the period Nov-15 to Feb-16. No data was returned in Mar-16.

Community Nursing Teams (north) - patient experience survey results - Oct-15 to Mar-16

The Friends and Family Test (FFT) is the first question asked in the community nursing team patient experience survey. The FFT is followed by a series of nine further questions. In addition, patients are asked specifically why they responded in the way they did to the FFT and for any suggestions as to how the service they have received could be improved.

Friends and family test

The FFT score is being calculated on the percentage basis as outlined in the NHS England guidance issued in Oct-14 and the Trust's target **'Would recommend'** score is 75%.

Team	Target	October 2015		November 2015		December 2015		January 2016		February 2016		March 2016	
		Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend
Community Nursing Teams - Northern	75	100	-	97	↓	100	↑	100	-	100	-	100	-
Barnstaple	75	100	-	100	-		?	100	?		?		?
Bideford	75	100	-		?	100	?	100	-	100	-	100	-
Holsworthy/Torrington	75	100	?		?	100	?		?	100	?	100	-
Ilfracombe	75	100	-	100	-	100	-	100	-	100	-	100	-
Lynton/Lynmouth	75	100	-		?		?		?	100	?	100	-
Out of Hours Northern	75	100	-	100	-	100	-	100	-	100	-	100	-
South Molton	75	100	-	80	↓	100	↑	100	-	100	-	100	-

Other survey questions

The responses to the nine questions which follow on from the FFT have been scored as follows: Yes, always / Yes, completely = 100; Yes, to some extent / Yes, sometimes = 50; No = 0. The scores have been calculated after excluding those patients who did not answer that particular question or considered the

question to be not applicable. A monthly score can range from 0-100. The rag rating is based on the following values: Green = 73 or over; Amber = 70-72; Red = 0-69.

The target score is 73.

Question	Target	October 2015		November 2015		December 2015		January 2016		February 2016		March 2016	
		Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend
Q1. Were you offered a morning or afternoon appointment for us to visit you in your home?	73	76.7	↓	80.8	↑	75	↓	75	–	55.6	↓	68.2	↑
Q2. Were you contacted in advance if we were unable to keep an appointment?	73	88.5	↑	88.3	↓	92.9	↑	59.4	↓	77.8	↑	87.5	↑
Q3. Were you involved as much as you wanted to be in decisions about your care and treatment?	73	92.3	↑	94.1	↑	94.4	↑	90.5	↓	94.4	↑	89.1	↓
Q4. Have your family and carers been involved in decisions about your care as much as you would like them to have been?	73	88.6	↓	89.7	↑	94.4	↑	94.4	–	92.3	↓	93.8	↑
Q5. Before you received any treatments did a member of staff explain any risks/benefits in a way you could understand?	73	90	↓	88.6	↓	100	↑	90	↓	91.2	↑	90.9	↓
Q6. Did you see the nurse clean/wash their hands during visits?	73	94.2	↓	97.4	↑	100	↑	97.5	↓	94.4	↓	95.8	↑
Q7. Do you feel you had sufficient time with us during the visits?	73	96.2	↓	94.4	↓	85	↓	92.9	↑	94.4	↑	95.8	↑
Q8. Do you feel you have been treated with respect and dignity?	73	98.1	↓	98.7	↑	100	↑	100	–	100	–	100	–
Q9. Do you know how to contact our service?	73	100	↑	97.3	↓	97.1	↓	93.1	↓	100	↑	82.4	↓

Qualitative results

Throughout the 137 patient survey forms returned during the period Oct-15 to Mar-16, the nature of the majority of comments received was of a positive / complimentary nature.

Some examples of these are listed below:

1. The nurses are excellent in knowledge, skill, and attitude. They are concerned for my father's needs and for mine as a carer. (Barnstaple - Oct-15)
2. Nurses were kind, helpful & efficient. It's a help to not have to travel to Barnstaple to clinic. (Ilfracombe - Oct-15)
3. The nurses and response team are always there for me and are a warm and friendly team. (Lynton - Oct-15)
4. Always enjoy their visits. (South Molton - Nov-15)
5. Nurses are supportive and caring, making me feel very comfortable and encouraged with my condition. (Ilfracombe - Nov-15)
6. Happy with service. (Bideford - Dec-15)
7. They're alright. (Bideford - Dec-15)
8. All the nurses were kind, cheerful & efficient & always concerned for one's welfare. Their visits were always welcome. (Holsworthy / Torrington - Jan-16)
9. Very pleased with care shown from all DNs. (Bideford - Jan-16)
10. The staff are reliable and very professional. (Bideford - Jan-16)
11. Particularly good with catheters. (Bideford - Jan-16)
12. Very efficient. (Bideford - Jan-16)
13. I have received exceptional service. (Lynton - Feb-16)
14. The community nursing service is friendly and very helpful. (South Molton - Feb-16)
15. Because I am very pleased with their service. (Bideford - Feb-16)
16. I have a visit from district nurse twice, MH, & she treated me with tender care on my wounds. (Bideford - Mar-16)
17. The way in which they put the patient at ease and explaining what they were trying to achieve. (Bideford - Mar-16)
18. Good, friendly service at [age]. A friendly face & good care and help is just wonderful. Thank you for all the help. (Bideford - Mar-16)
19. Because they are very professional and caring nurses, always time for a chat and always smiling. (Ilfracombe - Mar-16)

Of the 137 patient survey forms returned, there was a total of 26 negative mentions / suggestions for improvement of which those receiving more than one or two mentions (accounting for 50%) were the patient perception for the requirement for more community nursing staff (10) and the patient perception that the nurses had too much paperwork to complete (3).

Community Therapy Teams (north) - patient experience survey results - Oct-15 to Mar-16

The FFT is the first question asked in the community therapy team patient experience survey. The FFT is followed by a series of ten further questions. In addition, patients are asked specifically why they responded in the way they did to the FFT and for any suggestions as to what could have been done differently to have made their experience of rehabilitation better or any other comments.

Friends and family test

The FFT score is being calculated on the percentage basis as outlined in the NHS England guidance issued in Oct-14 and the Trust's target **'Would recommend'** score is 75%.

Team	Target	October 2015		November 2015		December 2015		January 2016		February 2016		March 2016	
		Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend
Community Therapy Teams - Northern	75	100	↑	93	↓	100	↑	100	–	100	–	97.7	↓
Acute	75		?	100	?	100	–	100	–		?		?
Barnstaple	75	100	–	80	↓	100	↑	100	–	100	–	100	–
Bideford	75	100	–	89	↓	100	↑	100	–	100	–	100	–
Ilfracombe	75	100	↑	100	–	100	–	100	–	100	–	91.7	↓
South Molton	75	100	–	100	–	100	–		?	100	?	100	–
Torrington/Holsworthy	75	100	–	100	–	100	–	100	–	100	–	100	–

Other survey questions

The responses to the ten questions which follow on from the FFT have been scored as follows: Yes = 100; Yes, to some extent = 50; No = 0. In relation to Q2, Q8 and Q9, the responses have been scored as follows: Sooner than expected = 100; As expected = 100; Longer wait than expected = 0. The scores have been calculated after excluding those patients who did not answer that particular question or considered the question to be not applicable. A monthly score can range from 0-100. The rag rating is based on the following values: Green = 73 or over; Amber = 70-72; Red = 0-69.

The target score is 73.

Question	Target	October 2015		November 2015		December 2015		January 2016		February 2016		March 2016	
		Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend
Q1. Were you given a choice about when your first appointment would be?	73	74.5	↑	62.5	↓	80.8	↑	65.4	↓	79.2	↑	71.1	↓
Q2. When you were given your first appointment was it when you expected?	73	77.8	↑	80	↑	88.9	↑	86.4	↓	74.4	↓	79.4	↑
Q3. Did the team member who came to see you the first time introduce themselves?	73	94.2	↓	100	↑	100	-	100	-	100	-	100	-
Q4. Do the team members give you information in a way you can understand?	73	95.3	↑	97.6	↑	96.4	↓	100	↑	97.3	↓	94.4	↓
Q5. Do the team members you see treat you with respect and dignity?	73	97.2	↓	97.6	↑	100	↑	100	-	99.1	↓	98.9	↓
Q6. Were you involved in decisions about your care as much as you would like to have been?	73	96.3	↑	93.8	↓	92.9	↓	94.6	↑	95.3	↑	87.2	↓
Q7. Have your family and carers been involved in decisions about your care as much as you would like them to have been?	73	91.7	↑	87.1	↓	88.6	↑	98	↑	79.3	↓	88.6	↑
Q8. As part of your care plan you may have been allocated equipment to use at home. Was this equipment delivered when you expected?	73	97.5	↓	97	↓	100	↑	95.7	↓	91.7	↓	97.2	↑
Q9. As part of your care plan you may have been allocated a place at a clinic or class. Was this clinic or class made available when you expected?	73	78.9	↓	85.7	↑	100	↑	100	-	94.4	↓	92.9	↓
Q10. By the end of your rehabilitation had you achieved everything you expected?	73	87.1	↑	77.3	↓	82.5	↑	97.6	↑	85.9	↓	80.3	↓

Qualitative results

Throughout the 252 patient survey forms returned during the period Oct-15 to Mar-16, the nature of the majority of comments received were of a positive / complimentary nature. Some examples of these are listed below:

1. Every member of staff were very friendly and introduced everyone present. Extremely patient with everyone and made it a pleasure to go to the clinic / group concerned. (Barnstaple - Oct-15)
2. I couldn't have had better care from start to finish. (Bideford - Oct-15)

3. Experience of close personal attention by staff when in all the exercise routine - excellent. (Bideford - Oct-15)
4. Courteous, polite. Explained everything clearly. (Bideford - Oct-15)
5. Good advice given on all occasions. Always prompt at appointments. (South Molton - Nov-15)
6. D. your physiotherapist was so professional, polite, caring. A good experience. His advice is continuing to help me. (Bideford - Nov-15)
7. Unexpectedly valuable therapy delivered by dedicated staff. (Bideford - Nov-15)
8. B. was extremely supportive and professional in her approach, care and understanding. (Barnstaple - Dec-15)
9. Punctual - detailed explanations - considerate. (Bideford - Dec-15)
10. The service offered was tailored totally to my personal needs - including home visits. (Bideford - Dec-15)
11. Nothing by them was anything but positive and my rehabilitation was on-going and speedy due to their professionalism. (Barnstaple - Jan-16)
12. Very helpful and lovely people, very caring and gave me confidence. (Ilfracombe - Jan-16)
13. D., the young man from physio, gave me a set of exercises for my stiff neck & shoulders and I can now lift my arms above my head! They made so much difference to me. (Bideford - Jan-16)
14. Offered good, practical help. Found everyone knowledgeable and professional. Built confidence. (Torrington / Holsworthy - Feb-16)
15. Cheerful, helpful & punctual staff. Who were very kind & patient with my husband who has dementia. (South Molton - Feb-16)
16. The care I received following my fall was far better than I expected and I am grateful to everyone involved. Thank you all very much. (Bideford - Feb-16)
17. All good work was done at all times, they were very kind to me. (Bideford - Feb-16)
18. Stress-free and the simple exercises are easy to follow. (Barnstaple - Mar-16)
19. I was previously endeavouring to strengthen my limbs following a stroke, not aware that I could have been doing more harm than good by incorrect exercises so when I was shown by your physiotherapists the correct methods it made such an improvement. (Bideford - Mar-16)
20. Everyone was extremely efficient as well as being compassionate, friendly and helpful and caring. (Bideford - Mar-16)
21. As they took time to listen to my needs and help and patience they gave to me. (Ilfracombe - Mar-16)

Of the 252 patient survey forms returned, there was a total of 24 negative mentions / suggestions for improvement of which those receiving more than one or two mentions (accounting for 58.3% of the total) were the delay in the start of the treatment (6), delay between appointments (4) and the need felt for more follow-up visits (4).

Holsworthy Community Hospital

Friends and family test - quantitative results

The FFT score is being calculated on the percentage basis as outlined in the NHS England guidance issued in Oct-14 and the Trust's target **'Would recommend'** score is 75%.

Location	Target	October 2015		November 2015		December 2015		January 2016		February 2016		March 2016	
		Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend
North Community - Total	75	96.3	↑	100	↑	100	–	100	–	100	–	100	–
Bideford-Elizabeth	75	100	–	100	–	100	–	100	–	100	–	100	–
Holsworthy	**75**		?	**100**	?	**100**	–	**100**	–	**100**	–		?
South Molton	75	88.9	↑	100	↑	100	–	100	–	100	–		?

Friends and family test - qualitative results

Due to the small number of responses returned during the period Oct-15 to Mar-16, they have been listed in full below.

	Month	Friends and Family Test Response	Please can you tell us the main reason for the response you have given?	Have you any suggestions for ways we can improve the service?	Please tick this box if you DO NOT wish your anonymised comments to be made public.
1	Nov-15	Extremely likely	Everybody is so warm and friendly. Bells are answered swiftly.		No tick
2	Nov-15	Extremely likely	A great place to relax after an operation and to recover. Generally quiet but has its moments.	Easy to say but more staff perhaps.	No tick
3	Nov-15	Extremely likely	Friendly staff which is essential for a stay in hospital. Helpfulness from all members.		No tick
4	Dec-15	Extremely likely	There is nothing the staff would not do for the patients - how did you find them? I hope they are paid well. The catering staff too are marvellous.	Not possible.	No tick
5	Dec-15	Likely	I've had a very comfortable stay, my thanks to all the nursing staff.	None at all.	No tick

6	Jan-16	Extremely likely	Good treatment, good food.	No.	No tick
7	Jan-16	Likely	Very pleasant attitude from ALL MEMBERS of staff & considerate in the way they look after you.	More staff are required at all stations.	No tick
8	Feb-16	Extremely likely	It has the advantage of local community healthcare - so important for families in rural locations.	Provide later early morning medicine round.	No tick

---

South Molton Community Hospital

Friends and family test - quantitative results

The FFT score is being calculated on the percentage basis as outlined in the NHS England guidance issued in Oct-14 and the Trust's target **'Would recommend'** score is 75%.

Location	Target	October 2015		November 2015		December 2015		January 2016		February 2016		March 2016	
		Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend	Value	Short Trend
North Community - Total	75	96.3	↑	100	↑	100	–	100	–	100	–	100	–
Bideford-Elizabeth	75	100	–	100	–	100	–	100	–	100	–	100	–
Holsworthy	75		?	100	?	100	–	100	–	100	–		?
South Molton	**75**	**88.9**	↑	**100**	↑	**100**	–	**100**	–	**100**	–		?

Friends and family test - qualitative results

Throughout the 29 FFT cards returned during the period Oct-15 to Mar-16, the nature of the majority of comments received was of a positive / complimentary nature. Some examples of these are listed below:

1. Because of the dedication and hard work all staff have put into making my journey to recovery a very pleasant one. (Oct-15)
2. Excellent nursing throughout with most effective support (e.g. physiotherapy) services. (Oct-15)

3. Everyone is helpful and friendly. A very calm atmosphere, a pleasure to be here. All staff work very hard and it can't be easy at times. A big thank you all. (Oct-15)
4. I was more than pleased with the care I received. Everyone was caring and did all they could to make my stay good. I would like to thank doctors, nurses and all the staff for their kindness to me. I would recommend South Molton Hospital to anyone for care. Thank you. (Nov-15)
5. Marvellous, couldn't wish for anything better. Everyone lovely. Thanks to EVERYONE. (Nov-15)
6. Because I have been so well looked after. (Nov-15)
7. Friendly, helpful staff all the time I have been here. I hope this little hospital keeps open for ever!! (Dec-15)
8. I've been here about a month and it's been wonderful. The care is out of this world. All the nurses are just wonderful. They have given me my life back. (Jan-16)
9. I couldn't have had better care anywhere. (Jan-16)
10. Because I have been quite happy here and made friends and everyone has been extremely kind and thoughtful. (Jan-16)
11. Lovely helpful staff, nice atmosphere. Good food, nice size helpings for me and followed by tea. Very pleasant setting and surroundings. (Feb-16)
12. Cleaners extremely good. Nursing staff and all staff are excellent. Food very enjoyable. No complaints. (Feb-16)

Of the 29 FFT cards returned, there was a total of 10 negative mentions / suggestions for improvement. Due to the small number of negative mentions they have been listed in full below:

1. Answering the call bells quicker.
2. Only that the bathroom in door in room is difficult to move when using crutches. Maybe a handle midway through door would help in this case?
3. When it's a wash that needs improving every area 2 towels.
4. Night time renew pad time to long and soreness.
5. South Molton Community Hospital staff were very pleasant. Biggest problem was when they were short-staffed. Community hospitals are very important for the area & for rehab.
6. More attention but overall quite good.
7. A better overhead bed lamp to read by.
8. Headphones for radio / not to distract others.
9. More staff.
10. More of shower.

PH/16/22
Health and Wellbeing Scrutiny Committee
20 June 2016

Royal Devon and Exeter NHS Foundation Trust

Update for the Health and wellbeing Overview and Scrutiny Committee on Cancer Waiting Times at the Royal Devon & Exeter NHS Foundation June 2016

In November 2015 The Health and Wellbeing Overview and scrutiny committee was briefed on the challenges being faced by the Trust in relation to delivering cancer targets. Of particular note was:

- the 30% increase in demand over the preceding two years,
- the comprehensive plan to return the Trust to compliance against the cancer targets by April 2016 and
- the continued feedback from patients with 94% rating the cancer care they received as excellent or good.

Since the November briefing a great deal of work has been undertaken by clinical and administrative staff from across the Trust, with the successful implementation of many aspects of the cancer plan. In particular, additional capacity for endoscopic procedures, outpatient clinics and operations has been developed, which has significantly improved the performance of the Trust. Cancer pathways for Urology patients have also been redesigned by the Urology team with the aim of reducing the length of time taken to diagnose and treat patients.

Following the implementation of the improvement plan the Trust is now sustainably achieving the 31 day treatment target. Performance against the 62 –day referral to treatment target has improved significantly, with the Trust failing by only one patient over the target threshold in April 16, compared to 1550 patients referred into the service.

In November 2015 the Trust was inspected by the Care Quality Commission (CQC,) with the Trust earning a rating of “good” overall and outstanding for “caring.” Their report commented positively upon a number of initiatives which have been implemented in the field of cancer care, such as the “Prostate Specific Antigen (PSA) tracker programme” and the “Living with and beyond cancer” programme, which has been developed with support from Macmillan Cancer Support.

The Trust is pleased with the considerable progress which has been made over the past six months, however, the clinical and management teams continue to place considerable focus on making the achievement of all cancer targets sustainable, whilst working hard to maintain the high quality of patient care for cancer patients.

Adrian Harris

Medical Director

PH/16/21
Health and Wellbeing Scrutiny Committee
20 June 2016

Wider Devon Sustainability and Transformation plan and NEW Devon success regime Progress update

20th June 2016

1. Introduction

This paper provides an update to the Devon CC HOSC on progress with developing the Wider Devon Sustainability & Transformation Plan (STP) and the NEW Devon success regime. This brief update paper will be accompanied by a presentation at the meeting.

We have previously provided a briefing to Devon HOSC on the success regime. The success regime transformation planning process is now part of the process for developing the Wider Devon Sustainability & Transformation Plan. – This is the new strategic planning process for local health & social care systems (STP footprints).

NEW Devon and South Devon & Torbay CCGs came together in February 2016 to form the Wider Devon Sustainability &Transformation Plan footprint. – 1 of 44 such footprints across England. Angela Pedder, Chief Executive of the Royal Devon & Exeter NHS Foundation Trust, was appointed in April to the position of STP lead, which also incorporates leadership of the success regime, and she will take up this role on a fulltime basis from 1st July 2016.

Production of an STP by 30 June is a national requirement and provides the local strategic planning vehicle for delivering the NHS national strategy – The Five Year Forward View. CCGs were required to agree appropriate planning footprints and in dialogue with NHS England, NEW Devon CCG was requested to form an STP planning footprint with South Devon & Torbay CCG, and we have now begun the process of developing our joint STP.

2. Developing the STP

Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term.

STPs should not be seen as an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there. Plans will build on current strategies, but must achieve transformational change to achieve the required level of financial and service sustainability for the future

Key points to note from the planning guidance about STPs include:

> **Triple aim:** STPs are about the holistic pursuit of the “triple aim” articulated in the Five Year Forward View – better health & wellbeing, transformed quality of care delivery and sustainable finances.

Place based planning: by embracing the STP process, planning by individual institutions will increasingly be supplemented with planning by place for local populations.

Partner involvement and engagement: success will depend on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

Services to be included : As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including specialised services and primary medical care. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care.

Access to future transformation funding: The planning guidance is backed up by £560 billion of NHS funding, including a new Sustainability and Transformation Fund which will support financial balance, the delivery of the Five Year Forward View, and enable new investment in key priorities. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards.

STP Content: local systems are asked to initially focus on creating an overall local vision and develop their response to three overarching questions – *how will you close the health and well being gap?*; *how will you drive transformation to close the care and quality gap?;* and *how will you close the finance and efficiency gap?* STP communities need to work together to set out their ambitions for their populations over the next 5 years including embracing new models of care, delivering against the Government's mandate for the NHS and NHS Constitution as well as addressing the nine national "must dos" by the end of 2016/17, Namely:

- developing a credible STP;
- returning the system to aggregate financial balance by developing local financial sustainability plans setting out the mixture of demand moderation, allocative efficiency, provide productivity and income generation required for the NHS locally to balance its books;
- planning for sustainability and quality of general practice;
- achieving key access standards (A&E; ambulance waits; RTT; Cancer; new mental health standards;)
- implementing learning disabilities transformation plan actions; and
- delivering improvements in quality including publication of avoidable mortality rates by individual trusts

To be successful STPs will need to be underpinned by key enablers of change including harnessing technology and workforce redesign.

Progress to date

We submitted an outline draft STP to NHS England on 15 April. This set out our approach to developing the plan, leadership and governance arrangements and our early thinking on priorities. Feedback was positive.

A further draft submission will be made on 30th June 2016 which will reflect the progress made since April on the success regime transformation work, our ambitious plans for sustainability and financial recovery in 2016/17 (1st year of the STP) and how we are developing the broader strategic context around national and local clinical priorities.
The submission at end of June will still be at a relatively early stage and we will continue to develop the STP during 2016/17. This ongoing work will be supported by the structures and processes established by the Success Regime which are being adapted to accommodate the wider Devon footprint.

Key elements of plan content are developing as follows:

i) Development of a clear vision and core strategic narrative describing our ambitions for the whole STP area.

ii) The NEW Devon system the plans developing through the success regime will form 70-80% of the core content of the STP – the assumption being that financial recovery and future delivery sustainability are our system key priorities.

iii) Transformation plans in South Devon & Torbay will focus on the key deliverables contained within the previously agreed ICO business case which also includes development of a similar new model of integrated care.

iv) The three local authority public health departments have agreed to work jointly on two key elements of the STP - a common public health strategic narrative which captures the high level public health profile of the STP area population and the 10 main health improvement challenges. They are also working to develop a more comprehensive joint prevention strategy to meet the challenge in the Five Year Forward View.

v) Stakeholder engagement plans and activities to support development of key change proposals

vi) We are undertaking a full strategy stocktake across the two CCG areas as part of our planning work. We are aware that there is a significant number of separate strategic plans, some service-focused, some geographically / population focussed that are currently live across the STP footprint. We will review these plans and work towards ensuring that these are appropriately consistent and aligned i.e.:

- Consistent with the Wider Devon overarching STP aims and objectives
- Support delivery of the NHS five year forward view and in particular the "triple aim" ambitions for health & wellbeing, care & quality and finance and efficiency
- Contribute to the locally prioritised health outcomes improvement of the population and address health inequalities
- Deliver relevant clinical service / programme specific national and local requirements
- Are capable of being delivered through the emerging proposals for a new integrated model of care which is more user focussed and less reliant on bed based care

vii) We are establishing work streams to support development of key enabling plans – particularly workforce, IM&T and estates.

The draft plan will be shared with key local partners in July once we have developed the plan further in response to feedback from regulators.

3. Progress with the Success Regime

Background

The success regime was initiated in September 2015 to improve health, care, and financial sustainability in north, east and west Devon. Local clinicians and senior managers across health and care are developing an ambitious plan for major transformation and cultural change over the next five years.

Over the past six months, clinical leaders and managers in Devon have:

- Developed a new collaborative approach to working together that has enabled the NEW Devon CCG to be one of few organisations to achieve its financial control total in 2015/16. Developed and published the case for change that has widespread support
- Looked at different types of illness to understand what care support is needed for different people
- Looked at the quality and safety of current services and identified where they could be improved
- Identified 20 immediate ways in which the quality and delivery of services can be improved and selected 5 opportunities for accelerated implementation in 2016/17
- Understood where there are financial pressures in the local health and social care system and why
- Identified a list of potential options for service change
- Agreed and partially mobilised programme governance arrangements

Summary of the case for change

Services in Devon must change in order to become clinically and financially sustainable, and the key reasons for this are highlighted in the case for change:

- People are living longer and will require more support from the health and care system
- The system needs to respond better to the more intense needs of some parts of the population
- Some services such as stroke, paediatrics, maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered across the system
- Local health and social care services are under severe financial pressure, and are likely to be £398m in deficit in 2020/21 if nothing changes

Much good work is already underway across Devon to address some of the challenges described above. Operating as a single system builds on this, supporting and accelerating it.

Approach to transforming care

Transformation of provision will change significantly where health and care is delivered in the future. Greater integration across health and social care will mean that more care will be delivered closer to peoples' homes, preventing avoidable admissions and clinically unnecessary long stays in hospital. Bed-based activity will decrease and fewer beds will be needed in acute hospitals or community hospitals. This will require some recurrent investment in integrated services to deliver new models of care but will reduce other unnecessary recurrent costs by a much larger amount. It Is this shift in the model of care then, that will deliver a significant proportion of the financial savings and efficiencies that will close the system financial gap, whilst maintaining the quality and sustainability of services. Ensuring that integrated care services are connected to local communities, meeting the needs of the people they serve, is fundamental to their success.

Health promotion and disease prevention need to be a common element of all services, helping to optimise health and decrease the long term burden of disease. This theme will be developed further during the next phases of work.

The initial recommendations focus on five segments of the population, many of which have high needs and account for a significant proportion of the overall health & social care spend:

- Elderly with chronic conditions
- Adults with chronic conditions
- Adults with Severe and Enduring Mental Illness
- Elderly with dementia
- Mostly healthy adults

The clinical strategy group initially recommended thirteen interventions, which will provide better quality of care and access to services for these segments of the population:

- Health promotion & prevention
- Specialist input in the community
- Self-management
- Care coordination and care planning
- Integrated health and care hubs
- Improved access to mental health expertise
- Rapid response
- Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS)
- Multi-disciplinary teams (MDTs)
- Rapid access to specialist services
- Discharge support
- New model of community beds
- Seven day services in social care and community care

These interventions are being developed further in the next phase and more detailed information on populations will be used to design and plan how services can be delivered. The clinical group is currently exploring how the concept of locally based health & wellbeing hubs could be developed as vehicles for incorporating and integrating such a range of interventions.

Acute service considerations

Local clinicians have examined the potential options for making changes to the configuration of some services provided in acute settings. These changes are necessary to improve clinical quality, make best use of workforce, or efficient use of resources, or a combination of all three. The services under consideration are:

- Stroke
- Maternity services
- Paediatrics
- Emergency surgery
- Smaller vulnerable specialties e.g ENT.

Development of 2016/17 improvement opportunities and plans

Local clinicians and managers have prioritised five areas for accelerated implementation in 2016/17 which can quickly deliver clinical and financial benefits. These are:

- Savings from bed based care, especially reductions in acute length of stay.
- Savings from a reduction in elective care spend.
- Savings from continuing healthcare funding
- Savings from Procurement
- Savings from Agency staff spending in provider organisations in line with national expectations

In addition to this, the system has targeted some organization-specific productivity benefits.

As a result of these opportunities and other business as usual planning, Devon commissioners and providers have recognised the need to work to deliver a single system savings plan and the added benefits of doing so. Work is continuing to drive optimum benefit, through combined recurrent and non-recurrent measures in 2016/17. We expect this package of measures to deliver around £70m savings during 2016/17 (with a £100m full year effect in 2017/18)

The approach taken for 2016/17 is a test of the collaboration required over the longer term for the system to deliver benefits together. This allows the system to differentiate between what it would have been possible to deliver as individual organisations, and what is possible through working together more effectively.

Forward plan

To keep pace with the required progress timeline, a detailed plan has been set out for the next year. There are three key aspects of work which will need to be driven forward simultaneously:

- 16/17 priorities
- longer term strategic transformation
- formal consultation process.

A set of governance arrangements is being implemented to oversee this plan and the STP development. As a result of being in the success regime, NEW Devon has also benefitted from some additional external funding to meet costs of external management and technical support and the establishment of effective programme arrangements.

4. Stakeholder engagement & early thinking on potential consultation

Our working assumptions regarding consultation are:

- A common case for change to be agreed over north, east, west and south Devon (this requires input from South Devon and Torbay)
- A common vision for Devon to be agreed, reflecting the STP
- A common, overarching financial framework across the SR and STP will be developed and agreed by all organisations

These form part of important groundwork for consultation

It is envisaged a single comprehensive PCBC will cover the case for change, vision, new models of care and the options that flow from this. Consultation if needed is likely to cover stroke, maternity and paediatrics, and community hospitals, with different evaluation criteria being applied to each. In terms of the geographical areas needing to be taken into consideration in each case:

- Review of community hospital services is likely to cover North and East Devon. South Devon are currently preparing to go to consultation on this. In West Devon, a review may not be required.
- The review of stroke services is likely to cover the STP footprint
- The review of maternity and paediatrics is likely to cover the STP footprint

All of the above assumptions will be subject to professional legal advice.

NEW Devon CCG has already undertaken extensive engagement and consulted with the public and other stakeholders on a range of plans to transform community services. The dialogue on the context and specifics of these changes are continuing. We will though now build on and extend this engagement work as our success regime transformation proposals take shape. We are involving patient and public representatives in our planning and design work and we have undertaken 3 key public and community stakeholder group events – two took place on 18th May – one in Tiverton and one in Plymouth. A third took place in Barnstaple on 13th June. More engagement events and opportunities are currently being planned.

5. Recommendations

HOSC is asked to:

i) Note progress with developing the STP in preparation for the further draft submission on 30th June.
ii) Note progress on development of transformation plans under the success regime, including thinking on potential consultation
iii) Consider how they would like to be kept informed and /or engaged in these plans as they develop

Author: Laura Nicholas
NEWDevon CCG Director of Strategy &
Success Regime Programme Director

9th June 2016