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.

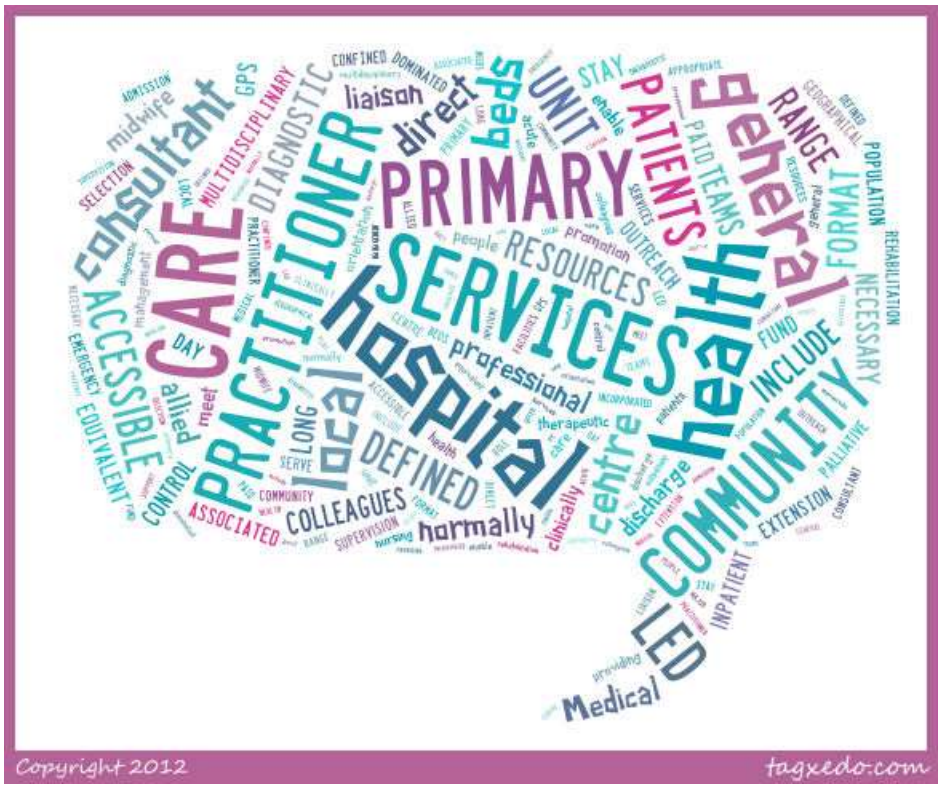
2.5. This investigation has taken place against the backdrop of much change in the NHS. Locally the Success Regime has been invoked to support the NEW Devon health system move to a position of financial sustainability. This carries the implication of changing models of care and the Scrutiny Committee 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:

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[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.

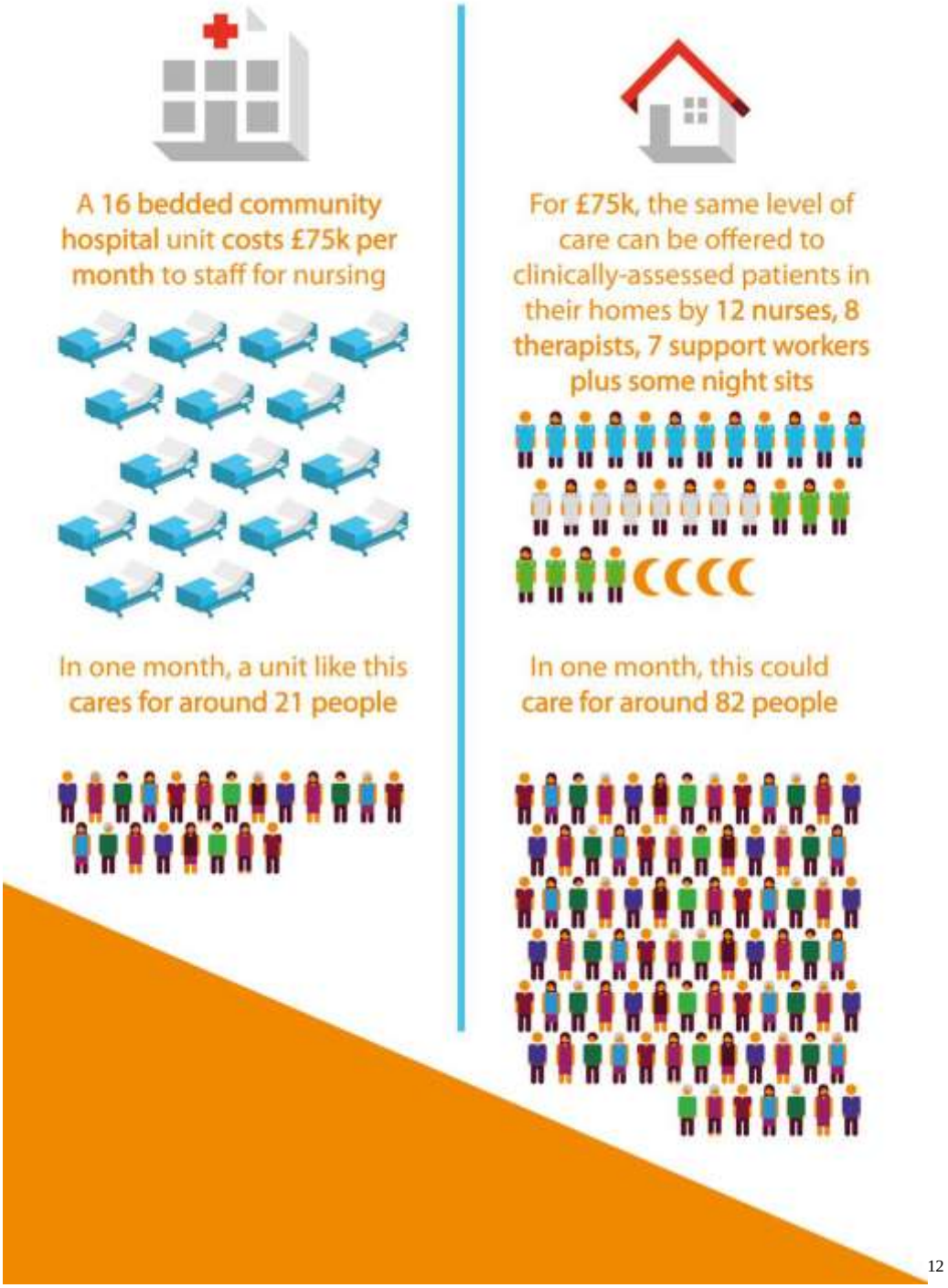
5.21 The Task Group asserts that the comparison between all models of care is required, notwithstanding the clinically different environments. The NHS have submitted evidence demonstrating the cost effectiveness of treating patients at home:

[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]



[12]

[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.

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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

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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:

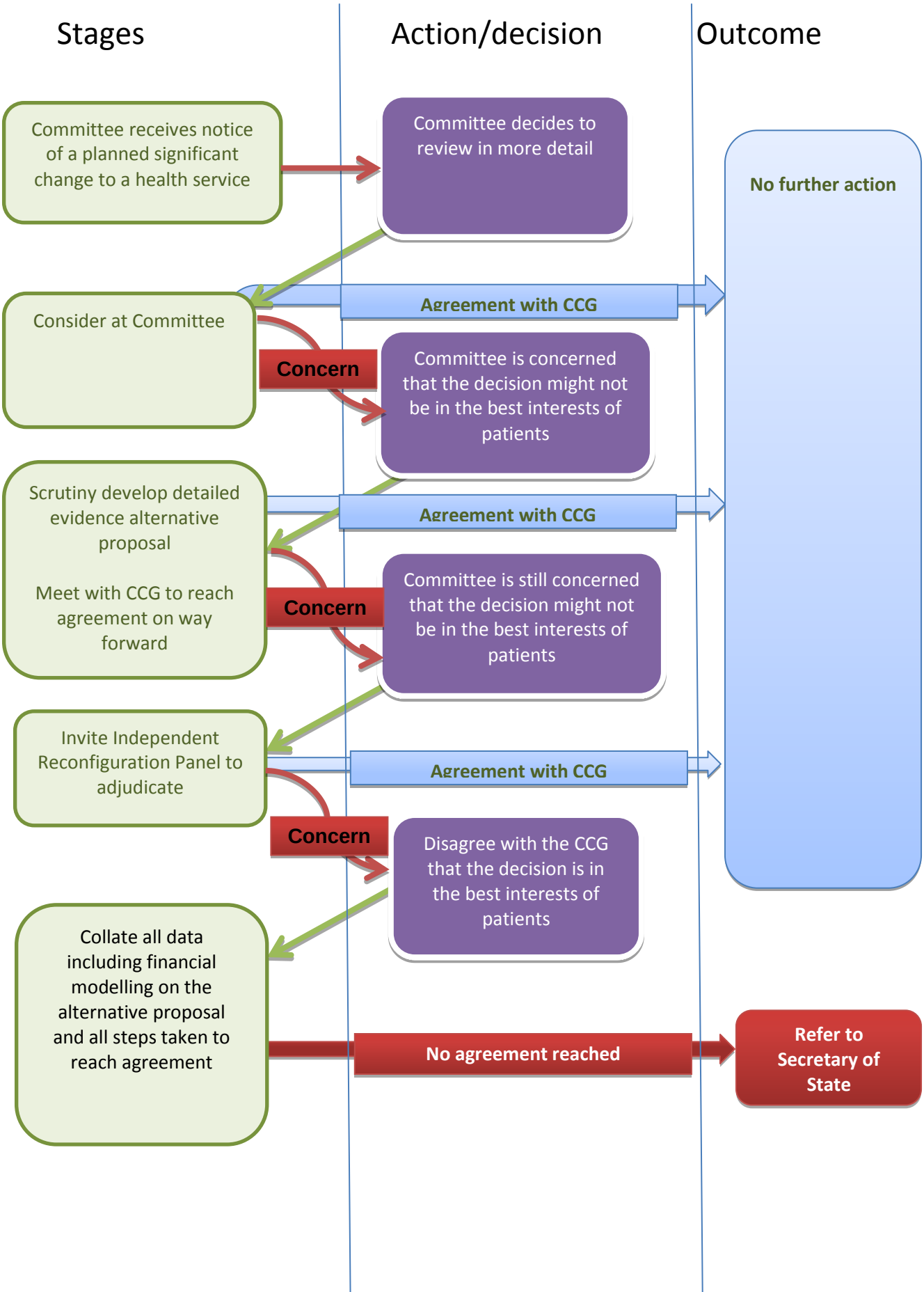
- An explanation of the proposal to which the report relates.
- An explanation of the reasons for making the referral.
- Evidence in support of these reasons.
- Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.
- 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

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.