HEALTHY PEOPLE
living healthy lives in healthy communities
Northern Devon

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Appendix 1 Board paper Torrington

Meeting Local Needs

Evaluation Framework

Introduction

A robust evaluation framework is required to support the Torrington Community Cares project.

It needs to:

1 Provide an evaluation of the community-based model of care already in place for the community of Torrington

2 Provide reliable information and evidence to inform longer-term decision-making regarding NHS services for the community of Torrington

Background to the Creation of the Evaluation Framework

An important part of the Torrington Community Cares programme is an evaluation of the home-based services already in place. This will take place over a six month period. The learning from the evaluation will be combined with a range of other information, particularly the views of the community in response to the *Meeting Local Needs: Involving You in Shaping Future Healthcare in the Torrington area* document, circulated at the beginning of October 2013.

This short paper provides an initial outline of the evaluation framework for discussion with the Oversight Group (composed of public representatives, councillors, clinicians and NHS representatives) in the first instance. Given the timescales involved, this Evaluation Framework is being used as a working draft. Data has already started to be collected and whilst further comments and suggestions are sought and received the proposed Evaluation Framework will be used as a template to collect initial data. However, we are open to feedback around this Evaluation Framework and can adapt this in line with any comment from the Oversight Group or the community.

But why is evaluation so important?

We want to provide a body of data and information, both quantitative and qualitative that can be interrogated by public and professional alike. We *think* we have a good model of care but we want to be *sure* of this before we make long term decisions.

We have committed to keeping the beds at Torrington Community Hospital open for eight weeks to provide a ‘safety net’ for local people. We are also running the enhanced services in the community alongside these beds and will continue with these enhanced services beyond these eight weeks and throughout the

evaluation period. Facts that flow from the evaluation will assist in interpreting the impact of the enhanced community model of care. This is important to:

- Consider the home-based care available locally in the context of NHS and health and wellbeing outcomes frameworks that are an important foundation for services
- Understand and evaluate the current delivery of the enhanced community service model already in place in Torrington and seek to identify and interpret the impact of this model.

There needs to be sufficient evidence from as many sources as reasonably possible to describe, analyse and interpret the impact of the enhanced community model of care.

We have already received a number of questions from the original task group, the members of the oversight group and also questions from members of the public at drop-ins and meetings.

Statistical evaluation will rely on general community trends at a higher level. It will then be reconciled with very local evidence, specific to the Torrington community.

To provide context for this, and offer valid parameters for the scope of the evaluation, we propose to apply other guidance for the evaluation framework. The following standards and measures have been used:

- NHS outcomes framework 2013/2014
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf
- Adult social care outcomes framework 2013/2014

  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141627/The-Adult-Social-Care-Outcomes-Framework-2013-14.pdf
- Corporate aims and objectives of Northern, Eastern and Western Devon Clinical Commissioning Group

  http://www.newdevonccg.nhs.uk/who-we-are/100069
- Operational Performance Standards, as applied to Northern Devon Healthcare Trust
- Nationally required data returns, including those previously agreed between Devon County Council and NEW Devon CCG as particularly relevant to community services.

How will we evidence that we are meeting these standards?

Evidence we are meeting these standards will be gathered from reliable and relevant sources, including those in primary, community, secondary and social care settings.

More local, qualitative information will be collected from patients, carers and family members, staff and the general public.

It is difficult to evaluate such complex and diverse data sets. Therefore all evidence will be considered in the context of a 'balanced scorecard' – a tool which helps capture what information is most relevant.

Appendix One is the composite summary Evaluation Framework and will be referred to directly throughout the remainder of this document.

A Balanced Scorecard to test the community model underpinning "Torrington Community Cares"

1. **Column One of the Evaluation Framework**

This is an extract from *Meeting Local Needs: Involving You in Shaping Future Healthcare in the Torrington area*

"Our evaluation of home-based nursing and therapy over the coming six months will help us understand just how effective – or otherwise – these services are.

The evaluation will focus on areas such as:

Patient experience – what did patients and their carers think of the service?

Staff experience – what did staff think of the service?

Effectiveness – what was the impact on admissions and other parts of the healthcare system?"

From these three questions, the following headings emerge – and it is these that will be incorporated into the evaluation scorecard:

1. Quality, Safety and Patient Experience
2. Accessibility and Patient Experience
3. Sustainability and Provider Experience
4. Affordability and Value for Money

National Outcome Frameworks and National Returns from Health and Social Care

2. **Column Two of the Evaluation Framework**

The National Outcome frameworks for Health and Social Care have been put together to encourage an integrated perspective in delivering care. Each of the outcomes has a mandatory set of information returns linked to it..

Qualitative and Quantitative Scope of the Evaluation in terms of Data and Information

3. **Column Three of the Evaluation Framework**

This:

- Identifies the elements of the Health and Social Care system that could show an impact as a result of the community based model
- Describes the indicators that will be interrogated to demonstrate impact, or not
- Includes qualitative and quantitative data, including impact on individuals as well as the wider system

  Includes any data capture from public feedback.

Information will be taken across all these data sources. This is important for a number of reasons:

- While the Torrington numbers may be small, an overall trend in service usage will give an indication as to whether community service investment is having the desired impact on community health and social wellbeing. Some of this investment will have impacted on Torrington.

- The additional investment in community services only commenced in 2011 so it ought to be possible to map any change in service use by date and this in turn will inform the baseline starting point.
- Community data has only more recently been captured electronically (comPAS) and while it offers a rich source of information it needs to be treated with sensitivity since it is reliant on clinical teams recording their information in this new way, and it is therefore there is likely to be a degree of variance..
- With the exception of the record of complaints and SUIs, this evaluation does not attempt to benchmark the qualitative data as that data capture has been established specifically for the Torrington.

Arrows showing against each of data elements represent the trend between the baseline and the figures at the end of the 6 month evaluation.

"Actions and Notes", to determine actions for the overall evaluation framework and note those where there is a weekly requirement for reporting.

4. Column Four of the Evaluation Framework

Further actions and key individuals may be added to this through input from the Oversight Group.

Table 1 is the template for the daily tracking of patients through the health system and will make up part of the Evaluation. Appendix Two describes the operational process in place underpinning this information capture over the eight week period.

Process and Timeline for Evaluation

There will be a number of reports to contribute to the evaluation of the pilot.

1. Some measures will be evaluated daily so that services can respond quickly if there are unintended consequences and lessons which can be learned in an iterative and timely way.
2. A second group of measures will be gathered weekly as headlines for the Torrington Community Cares oversight group and to support decision making.
3. A more detailed quantitative and qualitative set of metrics will be cumulative so will only be useful over a period of time and would need to take in to account the iterative changes described above. These will be used after 6 months.

1. Daily Evaluation

The working hypothesis for the test of change is that everyone from Torrington and its parishes should be able to be cared for in their own home, unless their medical need is such that they require admission to North Devon District Hospital (NDDH) or as part of the Gold Standard Framework

2. Weekly Evaluation

The purpose of the weekly evaluation is twofold.

- The oversight group needs to be assured on a weekly basis that the people of Torrington and its parishes are receiving the right care and conversely not receiving a poorer service as a result of not defaulting to community hospital beds. The table below is the template to be used for the weekly report. (Table 1)

The oversight group needs to give consideration to service provision in the round and attend to any unintended consequences that may arise from the test of change and associated impact on the Health and Social Care economy.

Table 1.

Torrington Community Referrals and Presentations to North Devon District General Hospital Week Commencing:		
Number of Referrals		What Happened?
Step Up (NHS No.)		
Step Down (NHS No.)		
Direct Acute Hospital Referrals and Discharges not known to the community team, taken from the ADD report (NHS No.)		

3. Cumulative Evaluation

The cumulative evaluation is:

- A continued consideration of the data and review which feeds into the determination of the future health and social care provision for the community of Torrington.

Validating the Evaluation Process

There is a commitment to organise independent scrutiny of the data to offer assurance to the public.

- Healthwatch have been approached to consider interviewing patients and carers about their experience of the enhanced model of care
- The Kings' Fund have been approached to see whether they could support the evaluation
- Plymouth University has been approached to see whether their new research network would be interested in being engaged in the evaluation process.

Prospective Scope for Evaluation

Data has been acquired detailing the uptake of hospital services by the people of Torrington and its parishes. This has been done by using secondary care data and identifying anyone attending services with an EX38 postcode, as a proxy for Torrington and its parishes and those patients outside the EX38 postcode, but registered to one of the two Torrington practices. These services include Outpatients, Day Cases and Inpatient (both Elective and Non-Elective) and diagnostics.

This information will be cross referenced with the Joint Strategic Needs Assessment (JSNA), to ensure the population's needs are mirrored by the activity delivered as described above.

The purpose of this work is to identify additional services, particularly outpatient appointments or minor procedures which could be delivered from Torrington hospital and would support patients being cared for closer to or in their own homes.

In addition, but also linked to the JSNA, would be services supporting and promoting Health and Wellbeing which could be delivered from Torrington Hospital. Examples might be smoking cessation services, alcohol support services, or healthy living initiatives.

By the end of the pilot there should be a predictive report scoping the potential for additional services delivered from Torrington hospital and an analysis of the impact.

Using the learning from feedback to towncouncil@lineone.net or via telephone 01805 626135

The Town Council are keen to hear from anyone in Torrington and its parishes when the delivery of health and/or social care gives rise to concerns. NDHT and Northern Locality CCG would like to support this and are keen to learn from any feedback as and when it is offered.

A system of feedback and communication has been established, whereby concerns are expected to be raised directly with the cluster manager via mobile telephone so that they can be addressed by the appropriate part of the health and social care system straight away.

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. Contact details can be found below: -

Patient Advice and Complaints Team
FREEPOST EX184
County Hall
Topsham Road
Exeter EX2 4QL

Telephone: 0300 123 1672 or 01392 267 665
Email: complaints.devon@nhs.net

Summary and Caveat

This document is intended to lay out the scope and depth of the evaluation of the Torrington Community Cares test of change.

It remains in draft form at this stage because it was always intended to be co-produced by members of the Health and Social care community and other interested parties.

It therefore at this stage represents the Health and Social Care perspective on measuring and evaluating the enhanced community model and is being used as a working draft.

In the spirit of positive and welcomed collaboration, should there be any suggested amendments to this evaluation, they will be given due consideration and incorporated where appropriate. But that being said, it should also be accepted that accommodating late amendments will not impact on the overall timescale for the evaluation.

Appendix One

FINAL DRAFT

EVALUATION FRAMEWORK FOR TORRINGTON COMMUNITY CARES

Advice from Information specialists is that we need to compare the study period with the pre-pilot Torrington baseline and bear in mind samples may be too small to draw a conclusion in which case we should consider wider studies and extrapolate conclusions from them.

The baseline should be drawn from a combination of those postcodes which relate to Torrington and its parishes, reconciled with the lists of registered patients at both of the Torrington General Practices.
Action SC

Column One	Column Two	Column Three	Column Four
Balanced Scorecard Torrington cares doc to embed (ww.torringtoncares.co.uk)	**Amalgamated National Outcome Frameworks for Health and Social Care** (JS, KB, CB and SMc) Appendix 2 NHS outcomes framework to embed SC outcomes framework to embed	**Amalgamated Metrics from the Task Group, 16th July and discussion with Information Services** (KB, NH, SC and the original Task Group membership)	**Actions and Notes** (KB, NK, EB, PH, NH and SC)
Quality, Safety and Patient Experience	**Improving quality of life for people, especially those with long-term conditions** Enhancing quality of life for people with long-term conditions (Domain 2 from NHS outcomes framework) Enhancing quality of life for people with care and support needs (Domain 1 from adult social care outcomes framework)	**Stakeholder experience** 1) What do service users think? 2) What do carers/ families think?	A questionnaire with a return prepaid envelope will be left with each patient and their family/carers for feedback at the end of their episode of care. **Action** NDHT Each patient/family will be invited to receive an independent anonymised interview by Healthwatch to record their experience of the model of care. **Action NDHT**

Accessibility and Patient Experience	**Maximising people's potential** Helping people recover from episodes of ill health or following injury (Domain 3 from the NHS outcomes framework) Delaying and reducing the need for care and support (Domain 2 from the adult social care outcomes framework) **Ensuring that people have a positive experience of care and support** Ensuring that people have a positive experience of care (Domain 4 from the NHS outcomes framework) Ensuring that people have a positive experience of care and support (Domain 3 from adult social care outcomes framework) **Providing care and treatment in a safe setting** Treating and caring for people in a safe environment and protecting them from avoidable harm (Domain 5 from the NHS outcomes framework) Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm (Domain 4 from adult social care framework)	<u>Impact on Wider Patient Flows</u> **Urgent care** <u>SWAST</u> Calls  Activation  Conveyance  Non-Conveyance  <u>Out Of Hours</u> DN Evening Activity  DN Overnight Activity  DDOC Activity  MIU Activity  Torrington 5pm – 8pm Activity  <u>A+E Activity</u> Presentation at A+E (non SWAST)  Conversion  **Primary care** Same day phone calls  Same day visits 	SWAST data **Action KB** ComPAS data **Action NH** DDOC Data **Action MW** NDHT Activity **Action NH** Primary Care Data **Action KB**

		Same day appointments ↕ In House MIU attendances ↕ Admissions – NDHT/ Community Hospital /Care Home Overall Contacts ↕ **Secondary care** Length of stay ↕ Discharge destination / Transfer destination ↕ Readmission rates ↕ Mortality ↕ **Social care** CDP referrals ↕ Social care packages ↕ **<u>What is happening in Torrington Community Services?</u>** End Of Life Assessment of referrals Activity and Acuity - Same day phone calls ↕ Same day visits ↕ Same day appointments ↕	NDHT Data **Action NH** **KB to speak to PH** **Action NH and RD** **Action – collected by the CCT team, to be analysed weekly and cumulatively (KB to organise)** **Action – To be discussed with the team KB / NK** ComPAS data, in discussion with the Team **Action KB/NH/NK**

		Overall contacts Length of Contacts Quality and safety Have there been any SUIs or complaints? What are we considering doing differently and what potential impact would that have had over the pilot period?	**Action KB to discuss with the Quality Team** **Action EB and KB**
Sustainability and Provider Experience		What is the staff experience of the success of the scheme? What do staff think about their (possibly new/ changing) roles? This is to include staff along the whole pathway including primary, community, secondary and social care staff full pathway. What operational and commissioning issues have emerged which have impacted either positively or negatively on the model of care?	**Action NK and EB.**
Affordability and Value for Money		Are the finances sustainable?	
Public View		Have the public been listened to? Analysis of % questions responded to and broadly what has been asked, e.g. initial questions might have been a lot about staff concerns, then perhaps about beds, then about wider system?	**Action – KB, RD and FE, from the feedback returns**

Appendix Two

Operational Process - 1st October- 26th November

The established process to support this evaluation is that any patient who lives in Torrington or its parishes, once approaching readiness for discharge from the Acute Trust, will be made known to the community team who will be responsible for making provision for their care at home.

Any patient who lives in Torrington or its parishes, who would have previously been a direct referral to the community hospital, will be made known to the community team who will be responsible for assessing the appropriateness of making provision for care at home

Some Torrington patients may present at NDDH, but receive a service from the Pathfinder team rather than being admitted to an NDHT (acute or community) hospitbed if that is more appropriate. The Pathfinder team are briefed to liaise directly with the Torrington community team for service provision and on-going support.

This process of communication will be made daily, via fax through Torrington hospital, where it will be received by the administrator there and an MDT clinical assessment will determine the optimum care for each individual patient. Any anomaly will be escalated to the cluster manager, and if required to the commissioner, for resolution.

A single telephone point of contact is now available for any Health or Social care services need s for Torrington and its parishes.

Should a person from Torrington and its parishes need a nursed bed and that provision of care cannot be delivered at home, an admission will be made to Torrington Hospital, if that was deemed the most appropriate place for that patient to be. This does not preclude the "spot purchase" of a bed in a Torrington nursing home should that be in the patients' best interest.

The community team have access to the ADD report daily (Admissions, Deaths and Discharges). This will be used daily to screen for those patients discharged but not known to the community team and those patients admitted within 24 hours who could receive a supported discharge home using the enhanced services.

Each case which falls outside the care pathways described above would be subject to a root cause analysis to understand the service requirement and help inform service provision going forward.

Appendix Three

Glossary	
A+E	Accident and Emergency Department. It is sometime referred to as ED, (Emergency Department)
Admission	In the context of this paper we are referring to an admission as an overnight stay to the Acute Hospital, which would be Northern Devon District Hospital (NDDH) or Royal Exeter and Devon (R,D+E) Note that NDHT stands for Northern Devon Healthcare Trust and includes all the community services and the community hospitals. NDDH is just the abbreviation for the main hospital in Barnstaple.
Admissions, Deaths and Discharge report	This is a report generated every 24 hours using data from NDHT. It is known as the ADD report and is sent to each practice daily so the GPs can see which of their patients have been admitted to hospital in the last 24 hours, who has been discharged and who has died. We are improving the report so in time it will also tell us who went to A+E, but then came home the same day and were not admitted.
Care Package	In terms of social care this would refer to home care support, or placement in a care home. It can also include on going nursing or therapy input, to meet a service users needs once they leave hospital. Sometimes this package is needed on a long term basis, sometimes it will only be required in the shorter term to help a service user recover and regain their independence. More and more social services home care packages also include a rehabilitation element. You will hear that called “re-ablement” It is exactly what is says and people receive their home care in such a way to encourage them to recover their skills themselves through encouragement and support.
Community Bed	All community hospitals have developed in different ways, but there are two key features which are common to them all. One is that a community hospital bed has 24/7 nursing care, unlike an acute hospital bed which has 24/7 medical care amongst many other things as well. This means that it is only safe to send someone to a community bed, either in a community hospital or their own home, if their medical condition is “stable”. By this we mean that we have diagnosed what is medically the matter, commenced a care plan that is seen to be working and there is not a likelihood of a rapid change or deterioration which would require urgent medical attention and more diagnostic tests.
Diagnosis on Discharge	When we are looking at the hospital data, it is important to know that when someone presents at A+E, and are admitted into the acute hospital, there is a “reason for admission” recorded. After diagnostic tests and the person is discharged, a “diagnosis on discharge” is recorded. This is not always the same as the apparent reason for admission, particularly with regard to the elderly frail. It is important because it is the diagnosis on discharge which tells us whether an admission was appropriate and/or whether we could have managed that person safely in the community.

Diagnostics	We use Diagnostics as a rather generic term for many and varied services and tests which are designed to tell us what is medically wrong and also when treatment is starting to work. The range of technical skills and expertise required and the complexity and sensitivity of some of the equipment is vast.
Elective/Non-Elective	Elective activity is a term used for any procedure (operation) that is planned and booked in ahead of time. Non-elective (which we sometimes call unscheduled care) is emergency work that is done straight away and hadn't been anticipated.
End of Life Care	The Department of Health (DH) has a strategy and large programme of work to support people at the end of their lives. End of life care is delivered across all services, from more generalist staff, through to specialist and hospices.
Enhanced community services	These are services based and delivered in the community, but require more specialist skills and competencies. As technology improves, it is beginning to become more and more possible to safely bring services out of the acute hospitals and closer to people's homes.
Episode of Care	This refers to a period of time where a service user receives a package of care and rehabilitation that is expected to come to a natural end, when the aims of the care and rehab have been met.
Gold standards Framework (GFS)	The GSF relates to people who are thought to be in their final year of life. It allows these patients to be flagged on GP information systems so community teams can see who their most vulnerable patients might be. The GFS website also specialises in offering training for our generalist staff to look after these patients with skill and knowledge.
Joint Strategic Needs Assessment (JSNA)	This is a public health generated report. Public health services are interested in understanding the profile of localities that would tell us about the health and wellbeing of local communities. These "Assessments" are refreshed annually and for example for Torrington it will tell you the top disease groups for your community. It helps public bodies plan what services are required now and in the future.
Length of stay (LoS)	This is a simple measure of how many days someone has spent in hospital during an episode of care. However, a LoS is directly affected by two variables. One is the reason for the admission ie how poorly they are, the other is whether they are able to return home. As a value LoS, Acuity (ie how ill they are) and ability to return home need to be considered together to give any meaning to LoS as a stand alone currency
Liverpool Care Pathway	This pathway describes the steps that health and care providers should follow when a person is considered to be dying.
MIU	Minor Injuries Unit.
Step down	This is sometimes referred to as "supported discharge." It means that someone is medically stable enough to no longer need acute care and so can leave an acute hospital, but still have care, rehabilitation or recuperative needs that require attention.
Step up	This is sometimes known as "admission avoidance" or "prevention of unnecessary admission". It means that someone might have care or rehabilitation needs, but these can be safely met in their own home or a non acute bed.