Appendix 5 Board Paper Torrington

Review of the Torrington Test of Change data at 8 weeks, 4 months and 6 months

1st October 2013 to 26th November 2013

and 1st October 2013 to 31st January 2014

and 6 Months Review

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1.Introduction

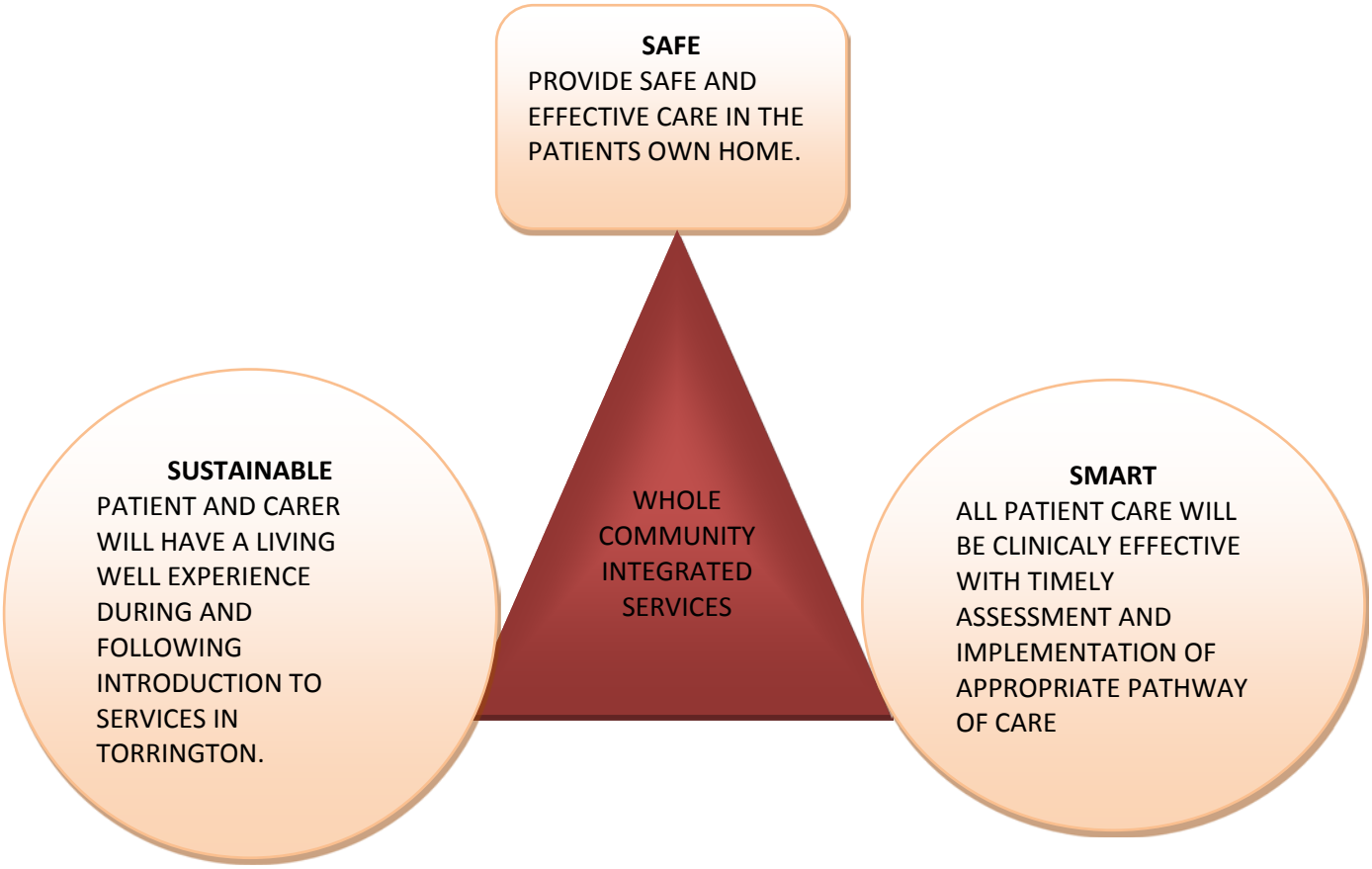
The purpose of this paper is to present the workings and progression of the 6 month evaluation, including initial and on-going findings of the reviews, of the new model of community care in Torrington.

It is structured to enable comparison between the initial findings of the first eight weeks and then at 4 and 6 months (up to 31 March 2014). It offers an opportunity to follow the discussion, potential interpretations and progress of the data analysis.

Using the Evaluation Document as the framework and the Oversight Group to provide independence and scrutiny the key question this review originally sought to address was whether piloting the model of community care in the absence of Torrington community hospital beds was safe for the people of Torrington and its Parishes and offered comparable if not improved quality of care.

Now, with the additional information, the focus also needs to be on quality and safety, sustainability, efficiency, and patient and carer satisfaction.

The diagram below was presented to the Oversight group as part of the 8 week evaluation.



2. National Context

Why are we doing this test of change now?

The NHS is facing a dilemma: the increasing rate of demand for healthcare due to the growing elderly population is outstripping funding. Current models of care are unsustainable and action is needed to establish the foundations of health and wellbeing services for current and future generations to ensure people remain as healthy and well as possible. And that when they need care they receive the right care where they need it with the best possible outcomes.

Health policies, nationally and internationally are focused on shifting care out of acute hospitals and in to the community. Integrating health, mental health, social care and voluntary sector services is the key to delivering quality and safe services, efficiently and effectively and integration is best achieved in the community, closer to people's homes.

The Government's plan for funding Health and Social care over the coming years is designed to support and promote this. The Better Care Fund which comes in to partial effect in April 2014 is intended to invest in and support those initiatives that promote care co-ordination and delivery across organisations.

This is a powerful incentive to review and redesign services to be as close to what the public tell us they want, and what we are hearing from our early engagement is summarised below:

3. What are we hearing from Northern Devon?

These statements summarise what we have heard so far from the people of North Devon.

> "The importance of ensuring that the services are co-ordinated and integrated; that organisational boundaries are "invisible" and services are wrapped around individuals and their families."
>
> "The importance of pathway based approaches to care with co-ordination through prevention to crisis and on-going care"
>
> "Personalisation and control over areas such as personal health budgets, information, education and self-management support."
>
> "The key role of carers and the need to support carer's health and wellbeing in addition to that of our patients"
>
> "The growing understanding of the need to shift the emphasis from the traditional focus on buildings and beds to more personalised care packages at home wherever possible"

"An emphasis on prevention and early help and the importance of information and positive approaches in particular to helping older people remain well where possible"

4. Local background to this report

The data used in this report is drawn from a number of health and social care sources. It is important to remember is that all the data represents only those people registered to either of the two Torrington GP practices. It is a unique analysis of people from Torrington town and its parishes and what has happened to their healthcare over this 6 month period.

The initial 8 week evaluation commenced on the 1st of October 2013 and an interim report was produced after the findings were presented to the Oversight Group, 13.01.14.

A second cut of data was taken on the 1st February, added to the initial data and presented to the Oversight Group on 24.02.14.

Finally the 6 month data was added and is presented here.

The hypothesis being tested is that the majority of people referred through the triage process either by GPs or NDHT, could have their care delivered in their own home by the enhanced community team to a consistently high standard and the model is both safe, sustainable and efficient.

5. What do we need to know?

The evaluation framework (Appendix A) has been used as the template for gathering health and social care data.

The first 8 weeks focussed on data to answer these questions:

1. Have Torrington patients been disadvantaged through the absence of Torrington community hospital beds?
2. Has the community team delivered the enhanced service?
3. Are the patients and carers happy with the service they have received?

Additional issues addressed over the full 6 months were:-

4. What are the financial implications of this model?
5. What are the service standards and how do they compare to the previous model of care?
6. What are the challenges of delivering care in the community? (Travel and Weather)

External validation and data capture are also important. This report takes in to account:

- Involvement of Healthwatch, Devon Senior Voice and the Torrington Town Council
- Views of the General Practioners (GPs), Consultant and senior community clinical staff
- The "Future of Community Hospitals Task Group" Health and Wellbeing Scrutiny Committee report,

2012

- The independent review of the evaluation data by Dr Helen Tucker, Vice President of the Community Hospitals Association

6. Baseline for understanding the data

All the data gathered represents any patient registered to the GP practices in Torrington. It was matched to the same data over the same time period in 2013, 2012 and 2011, where that data was available.

The data to be collected and interrogated was identified using the agreed evaluation template. The evaluation criteria were developed using feedback from the community about their fears and aspirations and was signed off by Northern Devon Healthcare Trust (NDHT) and the Northern Locality of the Northern, Eastern and Western Devon Clinical Commissioning group (NEW Devon CCG).

All health statistics are inevitably subject to random fluctuations and in any such case, the higher the volume of data used the more these fluctuations become averaged out. In Torrington, because the total numbers are small, it is important to remember that a fairly small change could be attributed to the random fluctuation, rather than a significant change in health care delivery. For this reason, all data presented became more accurate over the four month period and further still over the six month period.

It is important to note that there is a significant lag time for some of the data to be included in the evaluation due to validation and checking. All NHS provider organisations are subject to stringent standards in data quality and methodology.

7. Have Torrington patients been disadvantaged through the absence of Torrington Community Hospital beds?

If the model of enhanced community care with no access to Torrington community hospital beds put residents of Torrington at risk, we might have expected to see the following: (from the Evaluation Template)

1. An increase in Accident and Emergency (A&E) attendances
2. An increase in emergency admissions to the district hospital
3. An increase in attendances at the neighbouring minor injury services
4. More Torrington residents being admitted to other community hospitals
5. An increase in telephone calls to the “Out of Hours” (OOH) services
6. An increase in the calls to the ambulance service

7. An increased length of hospital stay at NDDH because there are no community beds to come to.
8. Have End of Life (EOL) patients been adversely affected?

The following sections outline the data in response to those 9 questions.

1. Was there an increase in A&E attendances?
Eight weeks - 01.10.13 - 26.11.13

There is a prevailing trend for increasing A&E attendances in northern Devon of 2-3% per annum. The following data should be seen within the context that we expect attendances to increase.

	2011	2012	2013	% from Baseline
Number of A+E attendances at NDDH by Torrington residents	344	347	346	0%

At eight weeks, it could be concluded that there was no change to the numbers of Torrington residents attending A&E at North Devon District Hospital (NDDH) over the three years, and therefore it suggested that the implementation of the new model of enhanced community care had not increased the need for residents of Torrington and its parishes to seek emergency help from A&E services.

Was there an increase in A&E attendances?
4 months - 01.10.13 – 31.01.14

	2011/12	2012/13	2013/14	% of Baseline
Number of A+E attendances at NDDH by Torrington residents	658	778	755	5%

At 4 months, there was a 5% increase in A&E attendances. This is not necessarily a significant trend; we cannot determine whether it is due to random fluctuation, a poor winter in 2012 and storms and flooding in 2013, or a change in health care delivery against the general trend. Also as this period of time covers January, which is traditionally the month of highest A&E presentations (when adjustment is made for holiday makers during the summer months).

Was there an increase in A+ E attendances?
6 months, 01.10.13 – 31.03.14

	2011/12	2012/13	2013/14	% of Baseline

Number of A+E attendances at NDDH by Torrington residents	1051	1186	1151	1119 = 3%

These 6 month figures would suggest that the trend for Torrington and its parishes over the 6 month period is no different from the rest of Northern Devon and therefore, the model of care has not impacted on A&E attendances.

We also compared A&E attendances to the number of emergency admissions as it quite often follows that people are admitted to hospital once they have been seen in A&E. If not admitted they return home; therefore there is a correlation between the two data sets.

2. <u>Was there an increase in emergency admissions to the North Devon District Hospital 8 weeks - 01.10.13 - 26.11.13?</u>

	2011	2012	2013	% of Baseline
Number of unplanned admissions to NDDH	133	162	134	-9%

These figures indicate there was no increase in unplanned / emergency admissions to NDDH and the number in 2013 is almost the same as 2011. This means that the care of patients was as 'planned' or managed as it has always been. Statistically, if we take the average across the three years there is a -9% reduction in emergency admissions.

<u>Was there an increase in emergency admissions to the North Devon District Hospital ? 4 months - 01.10.13 – 31.01.14</u>

	2011/12	2012/13	2013/14	% of Baseline
Number of unplanned admissions to NDDH	464	489	438	-8%

At 4 months, we saw an 8% decrease in emergency admissions. It is important to bear in mind that this compares to an overall 3% increase in A&E attendances, suggesting that the subset of those attending A&E who were ill enough to need a hospital bed actually reduced.

<u>Was there an increase in emergency admissions to the North Devon District Hospital? 6 months 01.10.13 – 31.03.14</u>

	2011/12	2012/13	2013/14	% of Baseline
Number of unplanned admissions to NDDH	700	719	636	710 = -10%

This figure of -10% represents a reduction in emergency admissions, which we propose is a direct result of avoided admissions, correlating with the increase in patients looked after at home and the additional activity in the community.

However, it is noted that this decrease was sustained during the winter of 2013 giving us confidence in the trend.

3. Was there an increase in attendances at the neighbouring minor injury services?
8 weeks - 01.10.13 – 26.11.14

	2011	2012	2013	% of Baseline
Bideford MIU attendances	56	53	51	-6%

Over the 6 month period between 5 patients in total attended other MIUs compared to 8 in 2012/13 and 5 in 2011/12.

Was there an increase in attendances at the neighbouring minor injury services?
6 months 01.10.13 – 31.03.14

	2011/12	2012/13	2013/14	% of Baseline
Bideford MIU attendances	222	195	184	209 = -12%

These numbers suggest a -12% decrease in MIU attendances for Torrington residents. Across the whole of northern Devon there is an overall -7% drop in MIU attendances which means Torrington is aligned to this area-wide trend. We could extrapolate that delivering the enhanced model of care does not lead to an increase in MIU attendances.

For completeness, the MIU figures for Okehampton were also examined. Two Torrington residents attended Okehampton MIU during the corresponding 8 week period in 2012, and in 2013 two also attended Okehampton MIU during the 1st 8 week period of this evaluation.

4. Were more Torrington residents being admitted to other community hospitals
8 weeks - 01.10.13 - 26.11.13?

	2011	2012	2013	% of Baseline

Community Hospital Admissions	18	18	8	-56%

The figures in the following tables are the total number of Torrington and parish residents who were admitted to a community hospital over the first eight week period 2013. Of these 8, 5 went to either Bideford or South Molton Community Hospitals. The remaining 3 were in Torrington Community Hospital. These three patients were reviewed by the consultant geriatrician and GPs on the 6th March as part of the medical review of patients who have been part of the test of change.

There are additional points to note:

In all of the 2011, 2012 and 2013 figures, 5 Torrington residents in each year were admitted to either Bideford community hospital or South Molton Community Hospital. Why? Each of those two community hospitals offer specialist services.

a. Bideford offers a dedicated specialist stoke service for patients who are no longer acutely ill, but need neurological rehabilitation. This kind of rehabilitation requires specialist skills at this stage of treatment and is strongly recommended in national guidance.

b. South Molton has the benefit of Consultant beds. This means that patients can be admitted to the community hospital because they are no longer acutely ill, but will have complex difficulties that still require the oversight of a consultant. South Molton also supports an orthopaedic rehabilitation pathway as its particular specialty for inpatients.

This practice of admitting patients to the care setting most able to meet their needs has continued unchanged as a result of the Test of Change in Torrington.

Were more Torrington residents being admitted to other community hospitals? 4 months - 01.10.13 – 31.01.14				
	2011/12	2012/13	2013/14	% of Baseline
Community Hospital Admissions	41	36	20	-48%

Were more Torrington residents being admitted to other community hospitals? 6 months 01.10.13 – 31.03.14				
	2011/12	2012/13	2013/14	% of Baseline

Community Hospital Admissions	56	45	26	51 = -56%

At the four and six month stages of the evaluation, far fewer Torrington residents were being admitted to other community hospitals.

The question from these figures then is "where did those patients go?" Previously these patients may have been admitted to Torrington community hospital and they are now being seen in the increasing referrals to the community teams. To validate this, the only other potential destination for patients would be either in to a residential or nursing care placement or a period of recuperative care.

Recuperative care forms part of the enhanced model of care and 5 patients received this form of care over the 6 month period, compared to just one in the same period the previous year.

5. Was there an increase in telephone calls to the "Out of Hours" (OOH) services 8 weeks - 01.10.13 - 26.11.13?

	2011	2012	2013	% of Baseline
OOH contacts	245	217	219	-5%

From the data received from the Out of Hours services, there was no rise in calls during the period of 1st October to 26th November between 2011 and 2013. There was a reduction in 2012 from the numbers from 2011, and this remained almost constant in 2013.

Was there an increase in telephone calls to the "Out of Hours" (OOH) services? 4 months - 01.10.13 – 31.01.14

	2011/12	2012/13	2013/14	% of Baseline
OOH contacts	522	549	514	-4%

Was there an increase in telephone calls to the "Out of Hours" (OOH) services? 6 months 01.10.13 – 31.03.14

	2011/12	2012/13	2013/14	% of Baseline
OOH contacts	864	816	773	840 = -8%

The Test of Change had no material impact on the number of calls to out of hours care providers.

6. Was there an increase in the calls to the ambulance service 8 weeks - 01.10.13 - 26.11.13?

	2012	2013	% of Baseline
Calls to the ambulance service.			

All calls	114	118	4%
Calls > 65	64	59	-8%
Treat and transfer, total	53	59	11%
Treat and transfer >65	41	32	-22%

NB the baseline is taken to be 2012 and 2012/13 data

Figures were only available for 2012 and 2013, but between the two years there is only a small variation in calls to the ambulance service from Torrington residents. The total numbers of calls overall rose by 6% from 167 in 2012 to 177 in 2013.

Was there an increase in the calls to the ambulance service? 4 months - 01.10.13 – 31.01.14			
Calls to the ambulance service.	2012/13	2013/14	% of Baseline
All calls	358	452	26%
calls > 65	208	201	-3%
Treat and transfer, total	218	226	4%
Treat and transfer >65	127	118	-7%

Was there an increase in the calls to the ambulance service? 6 months 01.10.13 – 31.03.14			
Calls to the ambulance service.	2012/13	2013/14	% of Baseline
All calls	440	522	440 = 19%
Calls > 65	249	237	249 = -5%
Treat and transfer, total	268	265	268 = -1%
Treat and transfer >65	153	136	153 = -11%

Numbers of calls to the ambulance service is increasing, year on year, across Devon, Somerset and Cornwall, and this growth in calls is consistent with the 6% increase described above. We will continue to keep this under review.

If we accept that the majority of the people cared for in Torrington by the community services team are highly likely to be over 65 years of age, this final data shows us that the implementation of the new model of care has not led to an increase in the use of the ambulance service.

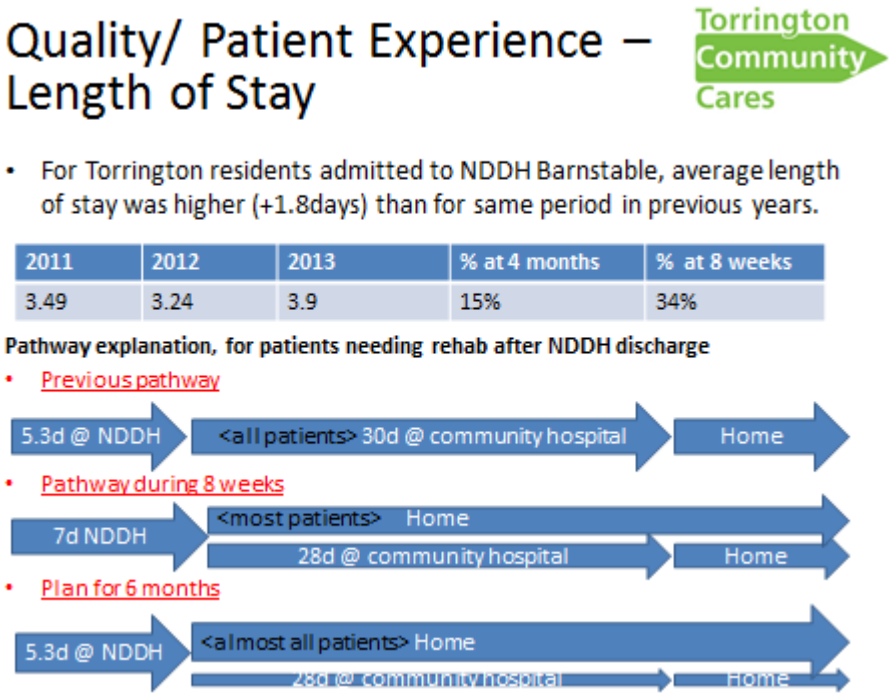
7. Was there an increase in the length of time Torrington residents stayed in NDDH 8 weeks - 01.10.13 - 26.11.13 ?

	2011	2012	2013	% of Baseline
Average length of stay at				

NDDH	5.2	5.3	7.0	34%

At 8 weeks, there was an increase in length of stay at NDDH for Torrington residents to 7 days. This was an expected result when introducing a new model of care and we ensured the community knew this data was being looked at carefully.

Below is a slide presented to the Oversight Group representing the length of stay during the first 8 weeks, 1st Oct to 26th November.



Looking at "previous pathway": it is true to say that patients with a 5.3 day stay at NDDH then stepped down to Torrington community hospital, where they would on average, stay for an additional 30 days, making the total length of hospital stay 35.3 days.

During the 8 week period three patients had a similar pathway, also resulting in a 35 day hospital stay, but the remainder were home after 7 days in total, a reduction in 28 days in hospital.

Over the period of the 8 weeks, two key issues became apparent that otherwise would not have come to the attention of the service managers.

- One was that it is difficult for members of ward staff at NDDH to understand how clinically stable patients could be looked after at home: yet the community teams have the experience of doing this successfully and the competence and capability to do so.

- The second was that the systems and processes for linking hospital staff and community staff needed to be reviewed and improved so that there was a far better interface between them and therefore a

more integrated pathway for patients moving between hospital and home.

However, the length of stay in hospital should be correlated with how ill a person is and it is important that these are recognised as averages.

Was there an increase in the length of time Torrington residents stayed in NDDH? 4 months - 01.10.14 – 31.01.14				
	2011/12	2012/13	2013/14	% of Baseline
Average length of stay at NDDH	3.49	3.24	3.9	15%

At 4 months, the length of stay at NDDH for Torrington residents had reduced from 7 days to 3.9 days average, very similar to pre-test of change data.

Was there an increase in the length of time Torrington residents stayed in NDDH? 6 months 01.10.13 – 31.03.14				
	2011/12	2012/13	2013/14	% of Baseline
Average length of stay at NDDH	3.7	3.4	3.9	3.5 = 11%

This data provides an average for the 710 patients in the baseline (51 of whom went on to stay at a community hospital and 659 of whom only had an acute stay); and 636 patients during the test of change (25 of whom went on to stay at a community hospital and 611 only had an acute stay).

611 patients who only had an acute stay in both periods had no impact on their length of stay; 25 patients who went on to community hospitals in both periods had no impact on their length of stay; and the 26 patients whose pathway changed **from** “Home - NDDH – Community Hospital – Home” **to** “Home – NDDH – Home” had a small increase from 3.5 days to 3.9 days.

To be clear so the figures add up, the remaining 74 patients from the baseline period did not attend NDDH during the test of change – as noted further above.

When looking at length of stay data, it is often also useful to review mortality data, i.e. the likelihood of a patient to survive given their age, sex and acuity (illness and dependence).

The following slide was presented to the Oversight Group on the 24.02.14 and is complex, but interesting and speaks directly to the issue of acuity. It is extracted from Dr Foster. Dr Foster is a national database that collects and compares health data across the country. The term “casemix” used in the slide is a clinical term and is used to differentiate the patients on a professional’s caseload who are clinically complex or

straightforward.

1st Oct – 28th Feb Source Dr Foster, all subject to statistical variability	2013/14	2012/13	2011/12	% increase or decrease
"Casemix" - % Patients 'expected' to die in hospital	3.2%	2.5%	2.9%	19% (Baseline = 2.7%)
Mortality "Relative Risk"	62	86	75	-23%
Length of Stay "Relative Risk"	93	93	104	-6%

The key messages from the mortality data are these:

These statistics refer to the Torrington patients with hospital stays. This data lags behind and so is only available for time period Oct 13 – Feb 14 currently. The nationally recognised and used Dr Foster database calculates "acuity" (illness) of patients using various indicators, in terms of an expectation of number of patients to die in hospital i.e. higher acuity would indicate more patients expected to die, and an expectation of numbers of patients with "long" lengths of stay i.e. higher acuity would indicate patients need to stay longer to recover/ be treated.

Compared to previous years, there were fewer patients in total and on average the database calculated acuity was 19% higher in terms of % patients expected to die in hospital. In other words the less acutely ill patients were not admitted to hospital and were cared for at home, so the remainder were more acutely ill on average, which suggests they were in the most appropriate care setting.

Crucially the "relative risk", or difference between what actually happened and what the database calculated was expected, remained better than the national average, i.e. patients in hospital received better than average care in terms of mortality outcome; and did not show a significant increase in mortality related to their relative sickness.

Relative Risk for Long Length of Stay has actually decreased although not to a "significant level" In statisticians terms, this means that the level of care in terms of length of stay outcome was not evidenced as worse or better than previous years, just about the same, but needs to be monitored over a longer period of time which may show evidence of an improvement. In other words, despite an increase in actual length of stay, given the increase in case mix/acuity it would be expected that the Length of Stay would increase about the same or possibly even more than it actually did.

Patients at the end of their lives have been a particular concern for the public and professionals and for the purposes of this report the data around end of life has been used as a proxy for the intensity and complexity that the enhanced Community team in Torrington can deliver.

This table was presented to the Oversight Group on the 13.01.14

Quality/ Patient Experience

Torrington Community Cares

- Has the change in service provision made a difference to the way we deliver End of Life care in Torrington?

End of Life Care	2012	1st Oct – 26th Nov
Number of patients	10	11
Time per patient	5.1hrs	11.8 hours
Visits per patient	7.5	14.5
Average visit length	40mins	49 mins

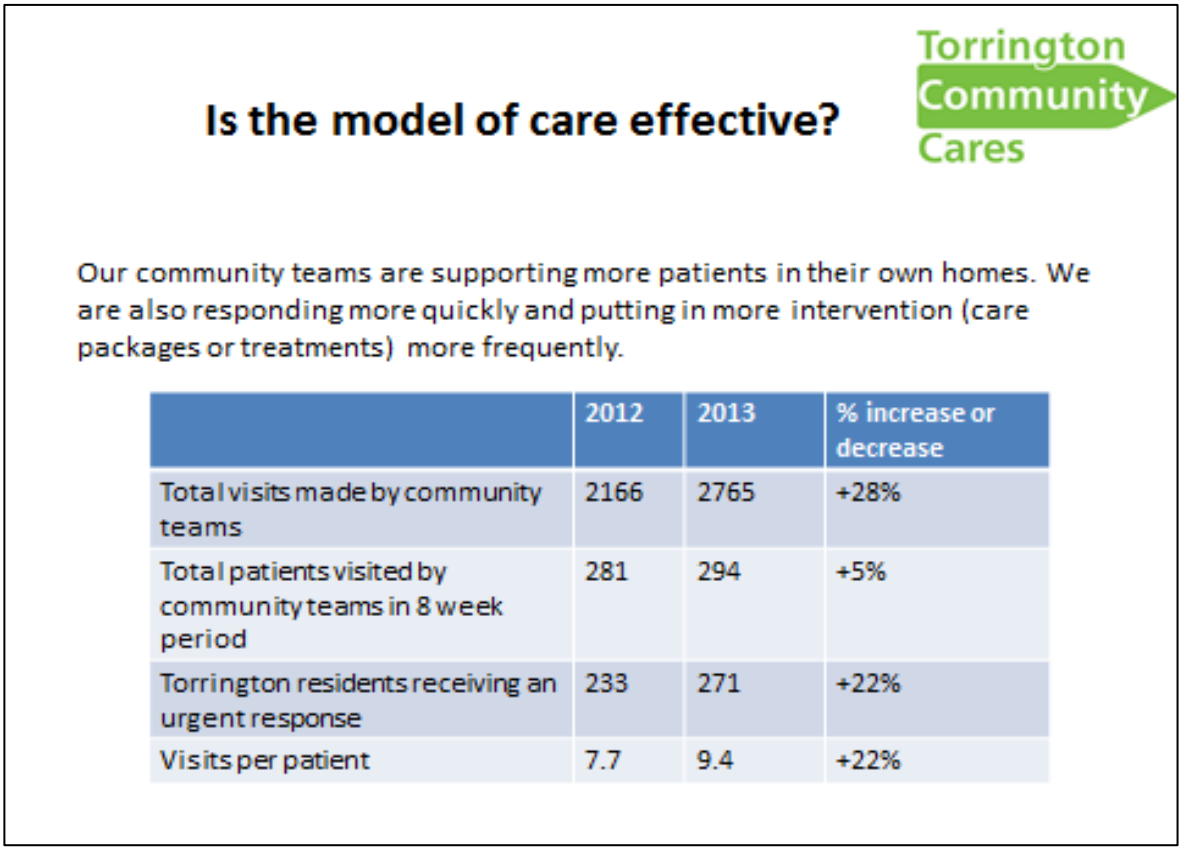
Whereas the number of patients receiving end of life care was higher during the first 8 weeks of the pilot compared to the baseline period, it was lower over the full 6 months compared to the baseline. Across the healthcare system, fewer end of life patients presented at all settings. This is believed to be due to a less severe winter, hence fewer patients with long-term conditions deteriorated to the end of life stage.

Has the change in service provision made a difference to the way we deliver end of life care? 6 months 01.10.13 – 31.03.14			
	2012/13	2013/14	% of Baseline
Number of patients cared for at the end of their lives	42	35	-17%
Average visit length	38mins	40mins	4%

All patients who presented to community services received longer visits on average than in the baseline period. They also received double the number of visits than they would have previously.

8. Has the Community Team delivered the enhanced service?

Whilst the inpatient beds were closed we expected to see an increase in the number of patients on the community team caseload. As demonstrated by the table below, this happened. This was the slide presented to the Oversight Group on the 13.01.14. from the first 8 weeks



Is the model of care effective?

Torrington Community Cares

Our community teams are supporting more patients in their own homes. We are also responding more quickly and putting in more intervention (care packages or treatments) more frequently.

	2012	2013	% increase or decrease
Total visits made by community teams	2166	2765	+28%
Total patients visited by community teams in 8 week period	281	294	+5%
Torrington residents receiving an urgent response	233	271	+22%
Visits per patient	7.7	9.4	+22%

Referring first to the slide above:

- It is of note that while 10 beds have been unused in Torrington Hospital, there has been an increase of 13 patients referred to the community team. The first row of the table shows an increase of +28% in the number of visits made, which we should expect because of the increase in nursing staff between 2012 - 2013 and the increase in therapies 2011 -2012.
- The third row of the table shows that we see more +22% patients classed as urgent and each patient receives more visits. The Oversight Group spent considerable time debating the meaning of this data which deserves outlining below.

One of the cornerstones of the new model of community care is that each patient and their carers receive a full assessment of their needs. Health and social care packages are then created to meet those needs. The number of visits from health professionals is determined and delivered depending on need.

One of the concerns raised by the Oversight Group was that aggregated and averaged figures in row four in the table above was inadequate and misleading. The table below shows a re-working of the information at the request of the Oversight Group.

Community Visits

Torrington Community Cares

Frequency of visits	2012	2013	% change
Once a week or less	53%	57%	7.5%
Daily to weekly visits	38%	31%	-18.4%
Daily	6%	7%	16.7%
More than daily	2%	5%	150%

These figures include those patients who are receiving care, but not necessarily the model of enhanced care (i.e those patients for example who have an annual Long Term Condition check or those receiving a flu vaccination).

The data shows an increase in the frequency of visits to the more poorly patients, which is what we would expect from this model of care.

The following tables show the enhanced community team data at 4 and 6 months respectively, also presented to the Oversight Group on24.01.14.

Data at 4 months.

We can summarise from the statistics above that there was a 5% increase in the number of patients referred to the community team. The real significant difference though is in the number of visits those patients received. This is evidence of the impact of the enhanced community service. The reason this is possible is because the community team has received extra funding to deliver this service.

The figures below summarise activity for the 6 month period. The trends are consistent.

The following slide was presented to the Oversight group on 13.01.14.

Sustainability

Torrington Community Cares

Overview of how the enhanced community nursing and therapy teams have developed over last two years

WTE stands for whole time equivalents

There has been an 87% increase in the clinicians in the community team

	2011	2012	2013	% change
Community therapy staff numbers (WTE)	1.44	6.9	6.9	+379%
Community nursing staff numbers (WTE)	7.3	7.4	12.2	+66%
Other community staff numbers (WTE)	3.0	3.0	3.0	No change
Total	**11.74**	**17.3**	**22.1**	**+87%**

As an interim measure of sustainability, retention of staff and sickness have been used as an indication of satisfaction at work. There is little short term sickness, between 1-2% which is low and over the 4 month period, no staff have opted to leave their posts. By 6 months only one member of staff has handed in his/her notice to take up a post closer to their home residence.

We also surveyed staff to canvass their views about working in the new model of care

9. Are the patients and carers happy with the service they have received?

The NHS Friends and Family Test has been offered to every person who has received the enhanced service from the Therapists.

The Friends and Family Test (FFT) provides a simple tool by which NHS services can gain information from service users on the experience of receiving care. The Test ensures transparency, helps celebrate success and also highlights areas for improved service.

Since April 2013, the FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care.

The FFT is already the biggest ever collection of patient views.The Friends and Family Test evaluates both positive and negative experiences of health care and calculates a positive or negative score for services. It is extremely sensitive to critism. The score can range from +100 (with everyone reporting a positive experience) to -100 (with everyone reporting a negative experience). In terms of scoring, the public sector would accept a + 40 score. NDHT aspire to achieve +60. The Torrington Enhanced Care service achieved +75. In accordance with known national guidance at the time, patients were asked the FFT question on discharge from the caseload. 28 patients completed forms out of 174 discharges from the therapy team, a a 16% response rate which is 4% below the national expected standard for acute inpatient surveys.

NDHT has committed to focus on improving the response rates to enable more confidence in the scores.While the scores per se seem high, it is somewhat called in to question by the low return rate. This will be taken forward and the reason for the low return rate determined.

In addition, in response to feedback from the Oversight group 31.01.14, a further specific set of survey questions in relation to Torrington only was launched in Jan-14. The opportunity was made to ask further questions over and above what was required by Friend and Family guidance.

The survey produced the same result of +75 as the previous survey and included the following questions.

- As part of your care plan you may have been allocated equipment to use at home. Was this equipment to use at home? Was this equipment delivered when you expected.
  63% said yes with 13% saying that the equipment arrived sooner than expected. Of the respondents 24% felt this question did not apply to them.
- As part of your care plan you may have been allocated a place at a clinic or class. Was this clinic or class made available to you when expected?
  This only applied to 50% of applicants and all responded positively with 13 % responding that the clinic/class happened sooner than expected.

- Were there times when you felt you needed more support from your community therapy team? 63% of the respondents felt they did not have times where they needed extra support. 38% felt they did need extra support and they got it (numbers are rounded up).

To capture the views of the patients and public, we have also asked the communications team to interview willing patients to understand their experience of care. These are some of the statements they made; each quote is from a different person; a full report of the patient interviews can be found in the Appendices of the Engagement report and published on www.torringtoncares.co.uk

"I have no complaints what so ever. They are all very competent and patient and I never feel rushed, they just stay for as long as it takes. The whole thing is really very organised. They are all very dedicated, we are lucky to have people like them!"

"They come as often as I need them, every day if necessary and there is never a time limit as to how long they are here. They always tell me to call if there are any complications so that is what I do. If it's after 8pm I call the on call doctor and they will come out – I have only had to do that once though"

"When you've got what I have got it is just terribly scary – it really helps just being able to talk things through. I've never come across a group of people that tend to us so well. It is really comforting. The nurses come in whenever we need them, we just have to ring".

A carer said - "What is wrong with X is one of the most terrible things you can have wrong with you, but knowing there are people around you that you can rely on makes it easier"

"I have to say that nationally the care profession do not get the best kind of treatment so far as Torrington and the NHS in Torrington is concerned. From my experience the people I have been concerned with have been remarkable. I didn't appreciate it at all the care I could have at home".

"The media tells all these stories about bad things happening to people, but from my experience it is completely different here".

10. What are the financial implications of this model?

There has been challenge that the "Torrington Test of Change" model of care will be more expensive than retaining the ten beds in Torrington hospital.

Below is a cost breakdown for the Torrington Hospital. It is important to note a number of issues:

- The staff costs for Torrington Hospital are calculated on the basis of the rota required to staff 10 beds.
- The overall cost of the hospital is the same, irrespective of bed occupancy.
- Average number of beds utilised at any one time in 2012/13 was in fact 6.7 rather than 10.

Torrington Community Hospital Costs

	£000
Medical Staff	30
Inpatient Beds	519
Total Inpatient Direct Costs	**549**
Admin & Building costs (utilities, rates & maintenance)	177
Therapy support (from community services) & other patient services (pathology, radiology)	67
Total services including building costs	**793**
General Corporate Overhead Allocation @ 20%	158
Total Including central overheads	**951**

The direct cost of running this 10 bedded unit as described above (i.e. minimum cost) for the health economy is £549k per annum.

Torrington Community Services Costs

	£000
Original Community Nursing and Therapy	504
Additional Community Funding	383
Total Community Funding	**887**

£383,000 is the cost of the additional nursing and therapy services needed to support the new model of care in the community setting

The cost of running the community services prior to the enhancement of the service in 2011 was £504k per year. With subsequent investment, the cost of the Enhanced Community Services is £887k per year showing an increase of £383k per year.

In other words with the building retained, the health economy would save £549k per year on inpatient bed costs and incur an extra cost of £383k per year in the community, making a net saving of £166k per year.

Additional savings can be identified from the reduction in emergency admissions as a result of the investment in community services. Comparison with the baseline period in 2012/13 showed a reduction in emergency admissions of 74 admissions. This equates to a saving of £80k per annum based on the average general medicine tariff at a marginal rate of 30%. At full tariff the saving would be £266k.

	Torrington £000
Total Inpatient Direct Costs Saved	549
Additional Community Funding	-383
Savings from Reduction in Emergency Admissions	80
Net Savings	246

11. What are the service standards and how do they compare to the previous model of care? How do service standards compare?

This is an important question. As part of the assurance that community services are as good as, if not better than the services prior to the changes, there was a comparison between the service standards for community hospital nurses and community staff, registered and unregistered.

This comparison was done in the context of the enhanced community services and the additional clinical skills required in the community to deliver the enhanced service.

We used national and professional documentation to ascertain the benchmark for service delivery and assess community service provision from that.

For the six month evaluation, we compared the job descriptions for the different nursing staff. Community nurses who have completed the Community Nurse Practitioner Degree level modules are the only nurses with an accredited additional qualification over and above the requirements to nurse in a community hospital. The key difference is that the Community Nurses have continued exposure to a critical mass of patients with a variety of condition which keeps their skills “current and relevant” this is more challenging in a small bed base hospital as community nurses have a case load of 460 as posed to 26, based on this evaluation over six months.

12. Challenges of delivering care in the community (Weather and Travel)

There have been specific concerns raised by the community in relation tothe responsibility of caring for older people at home with regards severe weather and poor transport links. There was a suggestion that being kept in a community hospital is safer; there are a number of challengesto this assumption.

- The likelihood of patients falling is increased if someone is kept in hospital, rather than being discharged and supported at home.
- There is an increased risk of infection as compared to being cared for at home. Clostridium Difficile and MRSA are more likely to be contracted in hospital than at home.
- Statistics suggests that it only takes 2.5 – 3 days in a hospital for a patient to begin to become institutionalised and more dependent. This is particularly challenging for people with cognitive impairment, but in both cases rehabilitation then becomes more difficult.
- There is a positive correlation between length of stay in hospital and being admitted to a care home.
- There is evidence to suggest that people cared for at home have a reduced mortality rate 6 months after their illness.

The antithesis of this is the public view that community hospital care provides a level of safety over and above that which can be assured at home.

It is true that being accommodated in a community hospital does assure 24/7 nursing availability. This does not by definition mean 24/7 nursing input is required. Indeed, most people who are suitable to be cared for in a community hospital do not require 24/7 nursing attention. This is important and great care was taken to ensure this distinction was explained throughout our engagement with the community. Listening carefully to the views of the public and reflecting on the clinical needs of those patients who are admitted to community hospitals, there appeared an inclination to favour an admission to community hospital on the basis of "just in case". This is not a sustainable financial approach and incurs risks as described above. It is also a misuse of a community hospital bed and could potentially put patients at risk.

If a patient is poorly enough to really require 24/7 nursing they should without doubt be in an acute hospital. There they have access to diagnostics, theatres, crash teams, specialist services, 24/7 medical input. There would be a level of clinical instability in their condition that requires the expertise of the acute hospital.

By definition, if their clinical condition is stable enough to mean that they no longer require 24/7 nursing, they are unlikely to require a community hospital bed and in most cases be better off cared for at home, in familiar surroundings without the additional risk of falls, infection and institutionalisation.

Weather

The issue of poor weather preventing carers and nurses reaching their patients has been repeatedly raised by the community. There is a real concern that snow in particular will strand patients and carers alike, leaving vulnerable patients without the care they should receive and would automatically receiveif they had been in a

community hospital.

It is already established that people who are poorly should be in the acute hospital; therefore there should be no one at known medical risk in the community, snow or no snow. There will however be two groups of patients who may be more vulnerable.

The first group are those who become ill unexpectedly during bad weather. This event could not have been anticipated and their treatment path would be no different to that which they could have expected in the past. Added to which, if someone is taken ill at home, it would be highly unlikely that they would be admitted to a community hospital because of the requirement for initial medical input and access to diagnostics.

The second group of patients will be those already known to the community team and in their care. As part of their ongoing care planning, the response to common eventualities will be outlined. This includes plans if the patient's condition suddenly deteriorates as well as severe weather conditions.

The Business Continuity Plan will also come in to effect in the event of bad weather. This plan is required of all providers and describes the actions the provider will take in extenuating circumstances to maintain the level of service delivery. The plan includes general arrangements such as transport and specific arrangements related to each individual's care plan.

Travel

There has been a publically expressed concern that community staff will spend a disproportionate amount of their clinical time travelling and that this would have implications for the carbon foot print of the service.

As a benchmark, NDHT carried out an analysis of the travel times of their community staff. It was discovered that the time spent travelling did not vary between urban and rural areas. In fact in Torrington, the length of time spent travelling decreased slightly per professional, although the increase in the team numbers suggests that the overall number of miles covered has increased.

The other group of people affected by travel will be those patients who would previously have been admitted to Torrington hospital who now go to a community hospital elsewhere, creating longer distances to travel for family and friends. However, it is worth remembering that the data over the 6 month period shows only 26 people needed a community hospital bed out of a total number of patients seen in the community of 460. The relatives of 460 patients did not need to travel.

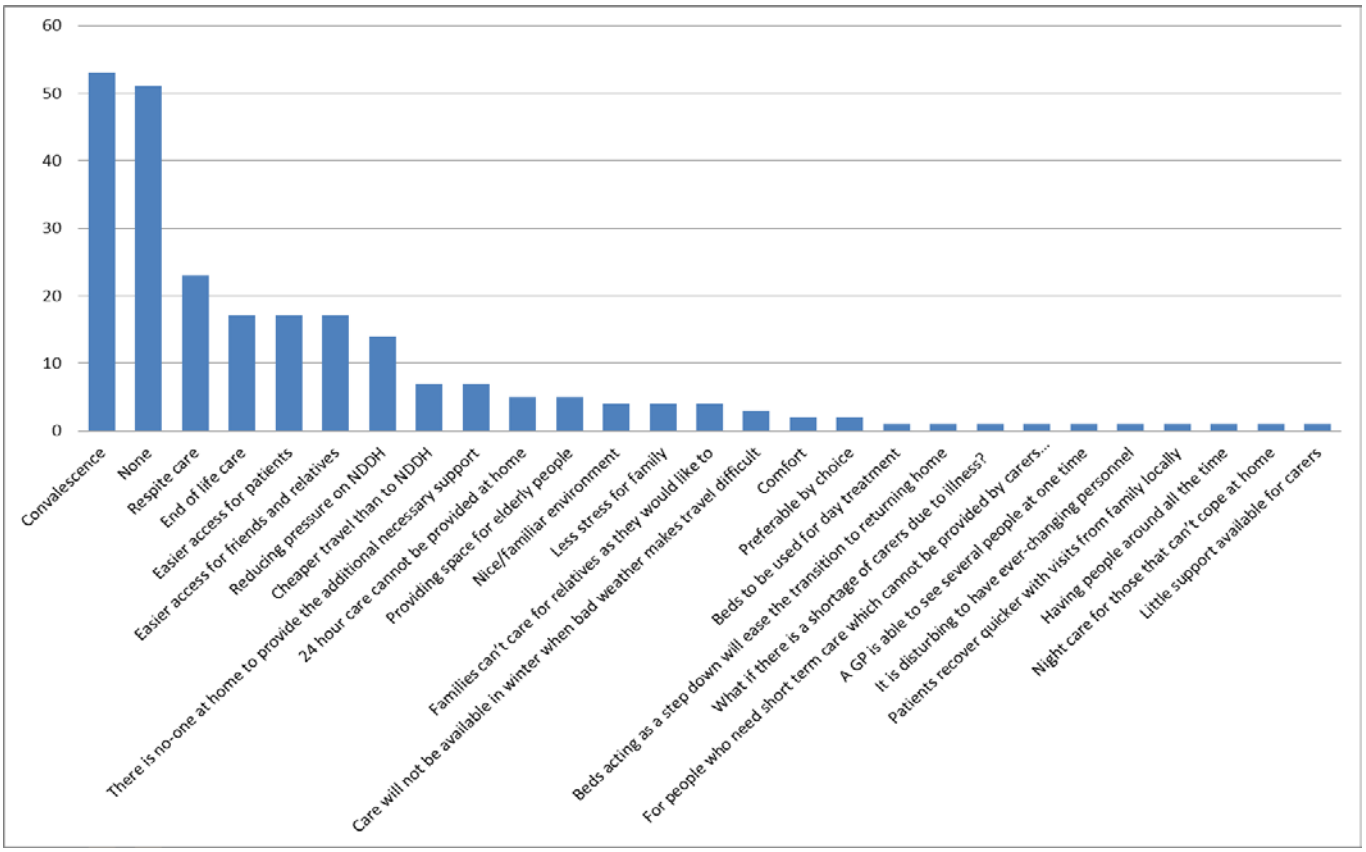
Of these 26 admissions to community hospital, a proportion would have been admitted to a speciality community bed, as they would have in the past. So while there is a negative impact for some, the numbers are small.

13. Involvement of Healthwatch, Devon Senior

Voice, Torrington Town Council and the Northern Locality Questionnaires

Healthwatch worked with NDHT, Northern locality (NEW Devon CCG) and “Save The Irreplaceable Torrington Community Hospital“(STITCH) to produce a questionnaire for the people of Torrington and its Parishes, canvassing their views on the future of Healthcare for the area.

In response to the Healthwatch questionnaire, the responses to the Devon Senior Voice (DSV) questionnaire and the Town Council Open Door sessions, NDHT and the Northern Locality CCG have compiled an action plan to address the issues that have been expressed (see graph below), but were not specifically addressed in the Evaluation template.



While the Healthwatch, DSV and Town council questionnaires do support the development of additional clinics and community services in Torrington, there is an underlying theme concerned with retaining the beds. To understand this in more detail an analyst was invited to interrogate the data from the questions specific to the Torrington questionnaires.

In summary, it can be noted that although 64% of the responses identified beds remaining in Torrington hospital, very few gave a medical reason for these beds. The themes were predominantly around respite, convalescence and accessibility for family and friends. There was concern about the availability of nurses to deliver care at home and some apparent confusion between the provision of health funded community care and Local Authority on-going domiciliary care.

There was also a request for some form of minor injury service to be repatriated to Torrington, but this would not be in line with the national guidance regarding the unsustainability of such services.

14. Views of the General Practitioners (GPs), Consultant Geriatrician and senior community clinical staff

The Torrington GPs have found themselves in a difficult position. The GPs are advocates for their patients and as such one Practice wanted to share the public sadness at the temporary closure of the beds. In a recent letter to the CCG there is both realism in recognising the challenge of delivering healthcare to an increasingly elderly population within a finite budget. This letter acknowledges that there is a lack of consensus amongst the GPs about the two models of care. They remain concerned about winter resilience and the security of the additional community funding.

As part of the pilot there has been a detailed examination of patients' notes and clinical pathways, undertaken by the consultant geriatrician, GPs and matron.

All of the patients were "step-down" patients, or in other words, those who had had an acute hospital admission previous to the admission to a community hospital.

The process for the review was that the secondary care notes (acute and community hospital) were analysed and a timeline drawn up for each one.

Each case was then discussed with a GP, Consultant Geriatrician, Hospital Matron and Board GP, using the timeline and the Primary Care notes.

Following this, the cases will be triangulated (awaiting update) with the records of the community teams to create the most holistic view of each patients contact with services before and after admission to hospital.

The outcome demonstrated:

1. There was consensus that the model of community delivery is safe.
2. There was consensus that the model of community delivery is clinically effective
3. For those patients who needed a community hospital bed, being cared for outside Torrington was inconvenient.
4. The patients who required a community hospital bed had all been rightly admitted originally to the Acute hospital as a result of an acute illness that would not have been treatable in the community.
5. These patients were very complex, frail and often close to their final illness. The care they needed was complex and would be best delivered in a unit with consultant support, over and above GP cover.

6. There was a dynamic relationship between medical need and social requirement; for example it did not necessarily follow that those patients medically fit to be discharged were able to go home for social reasons and it might be that by delaying a discharge for social reasons, led to clinical complications.
7. There was a negative correlation between the number of hospital moves and speed of recovery or rehabilitation.
8. Family perception had an impact on hospital stay.
9. Some longer stays in hospital were the result of supporting a programme of rehabilitation, which may or may not have been effective.

Other issues for attention involved internal communication processes between primary and secondary care.

As a result of the review of the clinical notes at this stage, it was agreed to examine the notes of those patients who stayed at home and avoided a hospital admission. To date all those patients who were supported to stay at home, remain at home.

The criteria for notes selection was indicated where patients required urgent visits and they remained at home. Of 20 sets of notes that were picked randomly only 6 could be scrutinised as community nursing notes are kept in the patient houses and on-going care was being delivered. Out of the 6 patients all of them lived alone. 1 patient went into Hatchmoor for end of life care another patient was supported at home for end of life care. All patients had involvement from therapist and nurses including Physiotherapy, Occupational Therapy, Community Nurses, Community Matron, Speech and Language Therapist, Hospice Nurse and the Community Rehabilitation Nurse. All remaining patients remained at home after treatment program.

15. Summary

The model of community care, tested in Torrington between 1st October 2013 and 31st March 2014 has shown to be:

- As good or better quality in terms of health and social outcomes than before
- Safe
- In receipt of positive feedback from patients through the Friends and Family Test (a 16% return rate was seen over this 4-month period)

- Demonstrates no negative impact on the local health or social care system of Torrington and its Parishes nor further afield in North Devon.
- More cost effective in terms of the direct comparison to the cost of beds
- More productive in terms of the community service available
- Reduces "exposure to risk" in hospital and creates less institutionalisation of elderly patients.

KM Burton

Commissioning Manager, “Care Closer to Home”

18.11.14