Northern, Eastern and Western Devon
Clinical Commissioning Group

Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

North Devon District Hospital
Raleigh Park
Barnstaple, Devon
EX31 4JB
Tel: 01271 322577
Fax: 01271 311541
Minicom: 01271 322746
www.northdevonhealth.nhs.uk

Direct Line: 01271 349566
e-mail: kate.lyons1@nhs.net

Cllr Andy Boyd
Via e-mail:
andy.boyd@devon.gov.uk

16 September 2013

Dear Andy

Thank you for your email dated 16 August 2013. In order to provide a thorough response, I have shared your email with the Northern Devon Healthcare Trust to ensure the operational details are covered.

The response you are receiving is a joint response authored by the Northern Devon Healthcare Trust and the Northern Locality of the NEW Devon Clinical Commissioning Group.

I apologise for the delay in replying but we wanted to give proper consideration to the requests for evidence and data, which meant asking several teams to respond to the different aspects of your questions.

In addition I also attach our notes from the drop in of 16 August which I hope will assist in responding to your questions. If, having digested this response, you have further queries, please do not hesitate to get in touch.

As you know, we are keen to ensure the whole community understands the issues and has full access to information and responses to questions. Given your role as an elected member, we would be very grateful for your assistance to this end to ensure that the public are able to express their views and understand the full rationale for the test of change.

The comprehensive nature of your correspondence and our response would therefore benefit from being shared. I would be grateful if you could confirm that you are happy for us to publish our response to you on our website.

I will answer your queries in full and in turn below.

1. **Transferring patients between community hospitals due to clinical need**

   Patients are rarely transferred between community hospitals. They are sometimes transferred between acute (NDDH, RD&E, Derriford) centres and community hospitals either as part of their rehabilitation or because their condition has worsened which requires more intensive medical support.

   The specific patient you refer to has been mentioned several times in our discussions. They were transferred between NDDH and a community hospital for a 2-week period of rehabilitation. The Northern Devon Healthcare NHS Trust has apologised to the family for the administrative error which caused the destination community hospital to be South Molton and not Torrington.

With regards the choice of community hospital for patients, some hospitals are more specialised than others and whilst we try to offer an inpatient admission to the hospital closest to the patient's home, sometimes this is not possible. Therefore, there will be occasions when a patient will be actively transferred to a particular community hospital that is not the one closest to home on the basis of clinical need and the facilities/resources on offer.

To answer your specific questions on this issue we have drawn from performance data over the last three years. We consider three years sufficient time to derive meaningful comparisons with patient flow and the use of healthcare resources. The other caveat is that we are only able to supply data for those services that are under our management.

1. There are on average 20 transfers annually between northern Devon community hospitals for clinical need (1% of total admissions to community hospitals). On average 5 of these form part of the stroke pathway.

2. There are on average 1,580 transfers of patients between community hospitals and NDDH for clinical need – 1,040 **from** NDDH; and 540 **into** NDDH. 10% of these flows in either direction are part of the stroke pathway.

3. How many patients have been discharged from NDDH on escalation (i.e. early to free up beds)?

   No matter how busy or under pressure the healthcare system is, we do not transfer patients early just to free up a bed. Whilst managing the flow of patients through our hospitals is a challenge, their care is not compromised

4. "How many failed discharges have resulted from early discharge?"

Referencing the answer above, we do not discharge 'early'. On occasions a patient transferred to a community hospital/ home will deteriorate and require readmission.

Readmissions, following an acute admission/discharge, are monitored in every acute hospital in England and fines are levied for an excess of readmissions. The rationale is to incentivise the correct clinical behavior of not rushing discharges.

Our readmission rate (casemix-adjusted emergency readmissions, using the accepted national (Dr Foster) methodology), is 93% of the national average and consistently below that average.

At Torrington the rate is 50% of the national average. We are "green" on this performance measure and hope you consider this sufficient reassurance.

5. "Where were those patients placed (NDDH/Community Hospital)?"

The answer to this depends on their clinical need and the assessment of their condition. If the patient needs an acute bed, they will be admitted. There is not a single answer to this question as this is a clinical decision made on the basis of the clinical needs of the patients.

If the patient has need of an acute hospital bed, i.e. they are seriously ill or injured they will be admitted to NDDH. If a patient has need for some short-term medical support, they will either be assessed as being appropriate for a package of care from the community nursing teams or be admitted to a community hospital.

6. How many patients have been discharged directly to their home unsupported (without care provision….or even food)?

NDHT has a clear process for managing the discharge of patients precisely to ensure that patients are discharged home in a supported way, if required. Often patients are able to leave hospital without any support.

If required, each patient has a care plan which identifies their onward care needs. Our Pathfinder Team, Complex Care Teams and Complex Discharge Coordinators work together to ensure the right package has been established to enable a patient's discharge to take place.

This approach drastically reduces the possibility of a vulnerable patient returning home without the required social, practical or physical support. Our staff would wish me to counter any implied lack of compassion in the way that patients are discharged from hospital and I know that if this did happen, the Board would see the incidents and would require an investigation.

To my knowledge, there have been no recent incidents of this nature.

7. **How many of these have become failed discharges?**

   Given the response to questions 4 and 6, above, there is no data available to support an answer to this question.

You have suggested we have failed to provide any of the information you have requested over the last 6 weeks. Reviewing the minutes of the Task Group meetings from 16 and 30 of July, it appears that we have endeavoured to answer all your questions, and indeed provided further information at the meeting of 14th August with Geoffrey Cox, MP. We emailed these notes around to all members on 13.8.13 and posted them on our website. Therefore not only have we provided you with the information, but we have also and repeatedly publicised that we have made it publicly available.

However, if there are any outstanding queries not addressed in both the minutes and this response, please do not hesitate to get in touch.

Moving onto your general concerns regarding the effectiveness of our engagement and communication activities to date, you will appreciate that we have accepted that there were some flaws in our approach.

From the outset, we have been and remain absolutely committed to engaging, consulting, sharing with, listening to and involving the public in discussions about the future of their healthcare, although you are correct that we had not envisaged a formal consultation process until the end of the pilot, which would have been designed to consult based on the evidence.

The engagement process, however included – on your advice – the establishment of a Task Group planned to meet monthly, then fortnightly, with membership from across the community. Through no fault or deliberate intent, this Task Group has failed in its purpose to ensure the community had confidence in the level of scrutiny and involvement in the plans.

This informal engagement/consultation has now shifted to a more formal consultation exercise because we heeded the concerns of the local community that we needed to take stock, do more to explain our rationale and describe the new model of care.

To ensure that we can continue this productive debate with the community without challenge on the process, we are moving to a formal public consultation.

However, the means of consulting or engaging the public will remain the same as they have been since 4 July, namely:

- Through the dedicated Torrington Community Cares website at www.torringtoncares.co.uk
- Via posts on www.patientopinion.com or www.great-torringtontowncouncil.gov.uk
- At our Friday drop-in sessions
- Further public meetings planned. These include dates of the 12th September at 6pm and the 14th September at 10am, both at the Plough Inn.
- By writing to the Trust chief executive and CCG locality Board
- Letters via the local media
- Meetings with local community groups by request or in response to invitations.

The documentation to support the consultation will be published shortly and will be shared with you.

In terms of the reference to the requirement to consult on pilots, no other test of change currently taking place in Devon has required a consultation. Hospital @ Home in the Exmouth/Budleigh area and the Rapid Assessment at Home project in Exeter have all been developed over the past year to test ways of working differently. The approach in Torrington is consistent to that in other parts of Devon, but we have heeded the strength of public feeling and revised our approach.

Moving onto your specific questions regarding the staffing numbers of the community teams:

1. The nursing team serving Torrington has been increased to from 7.4 whole-time equivalent staff to 12.2, supporting approximately 100 patients. These nurses make 180 face to face visits every week.

   In addition, the number of therapy staff serving Torrington has increased from 6.7 to 14.9 whole-time equivalents. Their caseload is approximately 80-100 patients at any one time.

   Some patients require daily visits, some weekly, some fortnightly, some monthly. The visits sometimes last 10 minutes and sometimes many hours. The decision on how much support a patient requires is a clinical one and not limited by any other considerations.

   We record all this data and can generate average visit length but it is not mathematically correct to divide the number of patients by the number of staff or visits. This does not generate an accurate calculation of the amount of care delivered to patients, as clinical need dictates that some will receive much less than the overall average and some much more. Please also bear in mind that, with the volume of referrals received, caseload also fluctuates over time according to overall need. We are always careful to treat each patient according to their individual needs.

2. In terms of the frequency of visit, again I hope that my previous answer clarifies this point adequately. The assumptions you have made (number of visits possible each day and that every patient requires a visit each day) are not correct and cannot be aggregated. But you have highlighted the point that high-need patients receive a high frequency of visits. Some patients receive care daily (even multiple visits daily), weekly, fortnightly or monthly – this is based on clinical need.

   The investment received to date in Torrington has produced a model of care that we are confident will support people in their own homes, instead of a hospital bed.

3. I am afraid I do not understand the question raised here about the evidence available from care agencies. Please can you expand on the problems you feel the evidence highlights?

Rest assured we are very well acquainted with your ocean liner analogy! And we accept that we provide a ‘safety net’ in order to test this model of care. For this reason the inpatient beds will be open for the period of the 8-week consultation.

As this test of change progresses of course we will continually review the patient feedback, the data and the views of stakeholders to adjust our approach and the model of care if required. The evaluation of the test will be crucial in deciding whether this is an acceptable, effective and safe model of care for the community of Greater Torrington.

Please bear in mind that the enhanced and expanded community and therapy services is a model of care that is currently already being delivered in Torrington following investment during the last 12 months. The test is to establish whether the community’s health needs can be served without 10 inpatient beds. Our clinical staff are very positive about their skills and expertise to deliver the right care to patients, and we are confident that when you hear from our nursing and therapy staff directly they will be able to provide assurance of this.

To answer your final questions:

1. **You must keep the beds at Torrington (and all other community hospitals) open, at least until there has been a full and transparent public consultation, and for as long as there is a perceived need.**

   We commit to holding a formal consultation on this issue.

   For the initial period of consultation, the beds will remain open to admissions.

   Once the formal 8-week consultation period has concluded, we will evaluate the usage of the inpatient beds, the ideas for creating a vibrant community hub in the hospital and ideas for new services to provide.

   No decisions about the future of the hospital or the inpatient beds have been made. We are maintaining an open mind until the end of the consultation and we have had the opportunity to review the data and evaluate the project.

2. **There is an undoubted need for a full and transparent public consultation**

   As stated previously, the same engagement exercises of public meetings, stakeholder meetings, drop-ins, media releases, posters, leaflets, letters and mail-drops will continue as planned as before.

   The formal consultation period will last for 8 weeks.

   There will then be a full evaluation which will be presented to the Boards of the NEW Devon CCG and the Northern Devon Healthcare NHS Trust.

3. **You need to correctly model and resource your proposals for "Care at Home", so that there is a plan for EVERY eventuality, and in order to totally ensure that no patient is put at ANY risk.**

   Over the next few months, we will clearly describe the model of care. You know as well as I that there is enormous confusion between the services provided by our community nurses and therapists and those provided by domiciliary carers, nursing homes, residential homes and a community hospital.

   We commit to ensuring there is much greater understanding of the elements of the service that we provide in people's homes and we would be grateful for your support in this endeavour.

4. **You have to fully engage with the public, taking due notice of their concerns – and not just listening.**

   I hope you will agree that by taking stock and adjusting our consultation approach, we have listened and acted in response to feedback.

5. **You must understand that if any of the above are ignored…there will be a Judicial Review! The public in Torrington will not accept anything less!**

   We understand that we are following a clearly defined process of engagement and consultation for a temporary service change.

   We hope to avoid any possibility of a judicial review (the health community can ill afford to redirect its resources for that purpose) by following due process during a consultation and ensuring that all members of the community – including current patients – are given the opportunity to have their say on the future provision of health services in their community.

If further consultation is required, for instance if the evaluation points to a permanent service change, then we will follow due process.

I hope that the responses given have provided sufficient detail to afford you confidence in our rationale and approach.

Please do not hesitate to get in touch if you require any further information.

Yours sincerely

KATE LYONS
Director of Operations
Northern Devon Healthcare NHS Trust

DR JOHN WOMERSLEY
Chair
Northern Locality, NEW Devon CCG