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Report

To

NEW Devon CCG

Torrington Community Cares
Independent Review of Service Evaluation

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1. Executive Summary

NEW Devon Clinical Commissioning Group (CCG) and Northern Devon Healthcare Trust (NDHT) have jointly agreed to develop a model of care for the 13,000 residents living in Torrington and surrounding parishes. They have developed the Torrington model, and carried out a "test of change" over a six-month period from 1st October 2013 to 31st March 2014. The evaluation of the test of change was to assess whether the model was safe, sustainable and a quality service (equal or better than before). This report is an independent review to determine whether the evaluation of the model of service has been sufficiently accurate, robust, balanced and objective in order to inform decision-making.

The Torrington model features an enhanced community healthcare service, with an increase in the number of community-based staff supporting people in their own home. The model gives a change of focus for Torrington community hospital with the temporary closure of the 10 inpatient beds in order to fund the enhanced community based home care and the creation of space in the hospital for more ambulatory care, clinics and other health and care resources.

During the test of change patients requiring community inpatient stays in general community beds have been referred mainly to Holsworthy (or Torrington when six beds were opened for a short period of time at the start of the test of change). Patients requiring some of the more specialist community hospital services such as stroke care and orthopaedic care continue to be referred to neighbouring community hospitals as before, such as Bideford and South Molton. The Torrington model is still in place following the six-month test of change whilst outstanding data continues to be collected, and the results of the evaluation so far are considered.

In order to review the evaluation of the Torrington model I have visited the hospital, attended meetings, interviewed individuals, received submissions and read supporting papers.

Within this report I have appraised in detail the two draft reports which are considered to form the outcome of the evaluation, which I refer to as the Evaluation Report and the Engagement Report. I have commented on each section of these reports, and made recommendations on improvements for subsequent versions. I have also re-presented data provided in order to clarify my own understanding and test the findings.

I have summarised my findings in a table setting out my view of what worked well and what has not worked so well in the evaluation and engagement process in chapter 10 of this review. I trust that this systematic appraisal will be helpful in providing a balanced view in recognising the considerable efforts of all concerned whilst identifying shortfalls and potential for improvement.

I am concerned that there is a fundamental disconnect between the formal scope of the evaluation, the nature of the engagement and the concerns of the local community. This has contributed in my view to the expressed levels of frustration and confusion. The scope of the evaluation was enhanced <u>home-based care</u> whilst the scope of the engagement was to <u>inform</u> local people and for their views on the future <u>re-use of the hospital.</u> The local community however wanted to voice their views on the <u>community hospital inpatient beds</u> that had closed whilst the test of change was taking place, and still remain closed. It is understood that the local NHS viewed the process as iterative, and widened the scope of the engagement over the process.

The scope was described as an iterative process however, and the scope widened during and beyond the six-month test of change developed.

Although described as a pilot, there is confusion within the community as to whether the patient voice and community voice can influence the outcome of the assessment of the pilot, and whether there is an option to return to the service model before the test of change that would reinstate the beds in Torrington hospital.

It is recognised by the CCG that the test of change of six months is relatively short in order to establish a new model of service and to evaluate its impact. Also that patient numbers, although significant, are relatively small from the closure of 10 beds and this is taken into account when modelling the impact of the change.

I have found that a considerable amount of work has been generated around the evaluation of the model, both for officers in the CCG and Trust and also for the community. Whilst much data has been generated, there have been limitations in the use, presentation and application of information in terms of supporting far- reaching decisions on the complex issue of healthcare design for a population. The CCG and NDHT have demonstrated a willingness to be transparent in the process such as through a dedicated website and offering multiple opportunities for engagement.

It is fair to say that officers in the CCG and Trust have gone to great lengths to be flexible and to adapt the process as it has evolved. They have responded to requests for more data, and carried out work to help inform the debate. This has resulted in an iterative process. However this responsiveness has raised expectations that the views being expressed by the community would influence the decision regarding the future of the inpatient beds.

The CCG and NDHT have invested considerable management time and resources into testing the model of care in Torrington, and it is right that this work is adequately reflected in the reports.

The CCG and NDHT wish to see more patients cared for in their own beds and in their own homes. This aspiration is also national policy that is backed by research evidence, and is also known to be the first choice for the vast majority of patients. It is clear that the CCG and Trust wish the Torrington model to succeed. The Torrington model increases the level of community staffing in order to be able to offer home care to more patients than before. For those for whom home care is unsuitable, GPs may refer patients to neighbouring community hospitals or a local nursing home.

The evaluation concludes that the change of service does not impact negatively on the whole health system and states that the test of change has demonstrated that the service is safe, sustainable and of quality. The data on the local health care system does not show any increase in usage of other services (such as A/E) and in fact shows a reduction in unplanned admissions to NDDH by patients from Torrington and surrounding parishes.

Evidence has been submitted and is now being investigated regarding potential adverse effect on a number of frail elderly patients and their family and carers. Examples of difficulties are access to alternative community hospitals and some difficulties with meeting patient and care needs in home based care. More attention to the specific patient group who previously benefited from the local community inpatient beds would have given the evaluation more focus.

The evaluation and engagement reports have formed the basis for a recommendation to continue with the Torrington model. The reports do not do justice to the work undertaken and the evidence collected by all concerned, and I have indicated gaps, opportunities to improve clarity, suggested some additions and recommended more cross-referencing.

Overall I have found that the evaluation has been carried out in a sufficiently accurate and robust way with regard to data analysis and interpretation of the wider health system. I have found that the process has been designed to be balanced and objective although it is clear that the CCG/NDHT support the new model of care. Views have been sought on services to be provided in the hospital functioning as a "hub." I have not yet seen evidence that the views of local people and stakeholders have been adequately captured, taken into account or influenced the detail of the overall service design. There is therefore scope to reflect on this more fully.

I have summarised key messages in my conclusion, and have included some learning points that have come out of discussions with those concerned. There is still work to do to develop a constructive way of working between the community and the local NHS, and to overcome the lack of trust by members of the community that was instigated by the initial announcement of the closure of the community hospital beds. Those involved all share a concern for health and social care services, and want to ensure that they are designed to be appropriate for local people. Ideally such a design needs to be co-produced by collaborative working.

The Draft Evaluation Report and the Draft Engagement Report are still being developed and in the next revision there is scope to improve their content and presentation to ensure that they are even more clear, comprehensive and informative. There will be opportunities to reflect the full extent of the work carried out, both as part of the CCG/Trust driven process but also as part of the community-led initiatives and the community voice. I trust some of the points within this report will be helpful in the redrafting of these documents, and they will provide a more robust basis for decision-making for the Boards of the CCG and NDHT when they consider recommendations being presented to them.

2. The Brief for the Review

Thank you for asking me to carry out an independent review on the evaluation of the test for change called "Torrington Community Cares." I have been asked to comment on the design, method and delivery of the evaluation and to provide a view as to whether the conclusions drawn are appropriate based on the outcome of the evaluation. The service change that has been piloted has been an increase in home-based support.

"The test of change looks at whether people who may ordinarily have been an inpatient at Torrington Community Hospital could instead be treated in their own homes by the Trust's expanded community rehabilitation and nursing teams. Ceasing the inpatient service would free up space at the hospital for other health and social care services, meaning some patients could be seen locally instead of having to travel to Barnstaple." Torrington Community Cares Website - News

The purpose of the pilot is to determine whether the new model of service could be deemed as "*safe, sustainable, and provide a quality service (as good as before if not better)."* The service change has been piloted from October 2013 to March 2014 by Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) and Northern Devon Healthcare Trust (NDHT).

I have assessed whether the evaluation is **sufficiently** accurate, robust, objective and balanced in order to inform decision-making. I have taken into account the complex nature of the service change involving multiple providers, the many variables that impact on individual patients experience and outcome for health care, the context for changing practice, and the known limitations of activity data collected for community based services.

The brief for this review as expressed by Geoffrey Cox QC MP is as follows: *"The review's objectives are to check that the conclusions and methodology of the existing report are sound, and that the evaluation has been properly designed to capture the true picture in terms of the evidence available. It will also check that the appropriate allowances and weightings have been given to the data collected. Any new evidence, submitted before 18th August, will also form part of the evaluation to ensure that as complete and accurate a picture as possible has been given."*

I have been guided by this requirement and have reported accordingly.

3. My Approach

The two evaluation reports I have been directed to that form the reported outcomes of the evaluation are:

- "Review of the Torrington Test of Change Work Book Version 11" *(Reference 1)*
- "Torrington Community Cares: Meeting local needs Public, Staff and Stakeholder Engagement and Involvement Report Version 3.0" *(Reference 2).*

I refer to these throughout this review as the Evaluation Report and the Engagement Report respectively. I have listed and referenced supporting documents in the appendices.

I have analysed supporting documentation from the CCG and NDHT. I have also considered documents from the Torrington Community Cares website and from my library of relevant publications and reports. I have also had submissions from staff, local residents and the community campaign group "Save Our Irreplaceable Torrington Community Hospital (STITCH). I have listed key documents in Appendix A.

I have visited the hospital (had a tour and talk), interviewed people individually and in groups, and attended meetings with the CCG/NDHT and STITCH. I have worked through the data collection, analysis, validation and interpretation process with the data analyst to help gain some understanding of the figures in the evaluation report. I have also had telephone calls to GPs and email contacts for clarification with those concerned. A detailed breakdown of interviews and meetings is included in the Appendix C. I trust that this has enabled me to carry out this rapid review of the evaluation fairly and openly, and to share my conclusions.

This review has required considerable attention to detailed documents provided by the CCG/NDHT and also from the community through STITCH. The interviews also generated substantial detail on the process and gave different perspectives about how this was being undertaken. Within this scope of this review it is not possible to get into the level of detail that those who have been working on this full time over a period of a year have been able to do. I am impressed with the attention to detail by both the CCG and the community, and clearly this matters deeply to all concerned.

With permission from STITCH and approval of the content, I have summarised their report and evidence (in shaded text to distinguish their authorship) in Appendices E&F. This has enabled me to reference key points more clearly and again test the evidence being submitted. I would recommend that the papers be read in full. I understand that the CCG/NDHT are responding formally to the STITCH evidence and are in the process of investigating the patient experiences submitted.

I have chosen to present some of this detail in tabular form in chapter 10, and this forms the basis of my review. I have set out my view on what has worked well and what has not worked well. This table may help inform the shaping of future exercises.

I want to thank all those who have shared their views with me, and have given this crucial matter considerable time and attention. I am grateful to all those who have helped me undertake this review.

4. Scope of the Evaluation

I was concerned to clarify the scope and parameters of the evaluation before undertaking the review, as there were different perspectives being described to me in interviews. Some confusion has been reflected in documents and in records of meetings, so for the avoidance of doubt I have set them out them out below as I understand them. The parameters of the evaluation are understood to be as follows:

The evaluation was focused on the enhanced community-based home care service.

> *"An evaluation of the community-based model of care already in place for the community of Torrington"* (Evaluation Framework)

The engagement was designed to inform local people.

> *"The purpose of these activities was to ensure that the community understood the test of change"* (Engagement Report)

The question being asked of local people was what services they wanted in the hospital in the future

> *"We were not engaging on whether the model of care worked or whether the inpatient beds should be reinstated. We were engaging on what services the residents of Greater Torrington would benefit from being able to access from Torrington hospital rather than NDDH."* Engagement Report Executive Summary Final Version 2

The re-instatement of inpatient beds at Torrington Community Hospital was not an option and not for negotiation.

> *"We would also agree with your point that essential services which cannot be a subject for negotiation need to be clearly differentiated from areas upon which engagement activity may be expected to have some influence."* CCG response to Healthwatch regarding Torrington 200

It is therefore important to make these parameters explicit and agreed, before considering whether the evaluation met its objectives and whether it in itself could be considered as accurate, robust, balanced and objective.

It is noted that over the course of the evaluation the parameters were widened in an iterative process in response to local views.

5. Context for the Review

Background

Torrington community hospital was established in 1908 and has served people living in Torrington and surrounding parishes for generations. Local people have demonstrated confidence in the hospital service that is a credit to the local health service and staff. The community hospital service is highly visible, with support for inpatients on the ward from the community such as visiting, transport and home support on discharge. The hospital attracts a high level of support, such as through fundraising from its League of Hospital Friends. The regard that the hospital is held in has been demonstrated through the attendances at public meetings to discuss its future and the attention that this test of change has provoked.

Evidence Base

A paper prepared by the Public Health department *(Reference 10)* considered the findings of systematic reviews on home care. The studies considered compared of home-based care with hospital care, which in each case was care in a District General Hospital rather than a community hospital. A key quote from the paper summarises the overall findings.

"A review of 27 studies from seven countries found that hospital at home care was as effective as traditional hospital care as long as participants were carefully selected. However, such services did not reduce overall healthcare costs. Good organisation, communication, and funding were key success factors."

Transforming Community Services University of Birmingham

The review of evidence draws out the importance of patient selection. This point may need to be clarified with local people, who translate this to accord with their view that hospital at home/home care is not suitable for everyone. The previous model of inpatient beds in TCH meant that patients assessed as not suitable for home care could still be looked after locally in a community hospital bed in Torrington.

The paper drew attention to the high levels of institutionalisation, falls and infections in hospital care, although again this refers to care in District General Hospitals. It is not clear that the same may be said of community hospital inpatient care, and a fuller understanding of the quality of care in a community hospital would inform this analysis of the research evidence.

The paper did not include an analysis of the benefits and value of community hospital inpatient care, which may have helped provide a more balanced view and demonstrate the value of community hospital services which are already provided throughout Devon. Given the prominence given to inpatient care in community hospitals, it would be helpful to demonstrate the evidence about their value and impact. A suggested addition is provided in the Appendix D.

The analysis of the evidence base was focused on the research on home-based care, to make the case for the new model of care with enhanced community nursing. If the model is being tested against the existing model, then evidence of the effectiveness of community hospital beds could have proved part of this analysis and consideration.

National Context

National policies support the objective of creating more capacity within the community, both within the patient's home and also in community facilities such as community hospitals. Simon Stevens has said *"Small hospitals have a big role to play, particularly in the care of older people,"* and he clarified this comment to be referring to community hospitals and small DGHs and was used to make a point about the importance of local services. This is described as a move away from centralisation.

Community hospitals offer local services that reduce the workload for large district general hospitals, and create a locally accessible service. This includes intermediate care, enhanced primary care and integrated care through partnerships. A number of CCGs have sought to optimise the amount of care within their communities by developing both home care and community hospital services, and reducing the use of acute hospitals.

It would have been helpful to have referenced examples of community hospital developments nationally. For instance, In Cumbria a new model of integrated health and social care, including inpatient provision has replaced the original plan to close some of the smaller inpatient wards in community hospitals which prompted a public outcry. This new model has led to the redevelopment of Cockermouth community hospital with a ward of 11 beds. In Gloucestershire, a major capital investment has resulted in the rebuilding of 3 community hospitals, ensuring clinical and diagnostic standards for the future. Proposals to close beds in community hospitals always prompts a negative reaction from the community, with campaigns and counter proposals. In Swanage the League of Friends successfully challenged the legitimacy of the formal consultation process and were successful in negotiating a pause in the process whilst plans for healthcare were re-visited with more involvement from local people. A similar challenge was launched for Ashburton Buckfastleigh and Bovey Tracey Hospitals, which managed to avoid bed closure plans going ahead. In a few areas, the local community have chosen to form a special charitable company in order to acquire the land and buildings, and manage the services directly, such as in Rye, East Sussex and Wells next the sea, in North Norfolk.

Other areas have redeveloped their community hospitals without beds, such as in the Health Living Centre, South Norfolk and Hartismere Hospital in Suffolk. Some have linked with care homes for NHS beds, such as in Ledbury in Herefordshire, enabling local NHS beds to continue to be provided locally but not within a community hospital.

There is considerable variation in the model of the community hospital, and it may be useful to research this more fully.

Announcement of the Test of Change

It is understood that the way that the closure of the beds was announced, and the short notice given, resulted in a shock reaction, and created an issue of trust from the community and community organisations that has yet to be redressed.

Scope

The test of change has been to assess whether patients who would otherwise have gone into an inpatient bed at Torrington hospital could now be cared for at home. The focus on providing as much care as possible within a patient's home is in line with national policy for care closer to home, and transforming community services. Whilst many people express a preference to be nursed within their own homes there is some concern that it is not always appropriate. Alternatives being offered in the Torrington model include a bed in a local nursing home, a bed in a community hospital outside Torrington, or a stay in NDDH. It is understood that there is not an option to offer local people both the Torrington community hospital inpatient beds and a community-based homecare service.

The pilot ran for six months, from 1st October 2013 to 31st March 2014. The 10 beds closed prior to the start of the pilot, and at the request of the MP and local people, 6 beds were re-opened for an 8-week period as the new service was being established. It is understood that this was in the context of a possible judicial review regarding a potential challenge on the basis of a lack of consultation. The beds then closed at the end of November. The beds have remained closed following the test of change, whilst the evaluation report is being compiled. It is understood that hospital staff have been redeployed into substantive posts. Additional community nurses and therapists have been employed for the enhanced team, and community staff teams such as the Complex Care Team (CCT) are based at the hospital.

The evaluation has been carried out on the enhanced community service, where local residents needing health care have received nursing and therapy support at home. The pilot has been evaluated, and data continues to be collected in order to monitor the impact on patients, the community and the local health and social care service.

An Oversight Group was formed with membership from those concerned, with terms of reference to make recommendations following the evaluation findings. As the report was incomplete for the July 2014 meeting, the group decided not make a recommendation.

The CCG accepted the recommendation of Geoffrey Cox MP that the presentation of the Joint Board Reports for recommendation be deferred whilst the evaluation report was completed and local people given additional time to submit further evidence. A public meeting is being planned that will be chaired by the MP prior to Board meetings.

The Health and Wellbeing Scrutiny Committee (H&WB Scrutiny Committee) were presented with a Final Report on Engagement (which also included the result of the 6 month evaluation) in June 2014. The Scrutiny committee is required to be consulted by NHS bodies on any proposal for a significant change in local health services. The committee has the right to refer to the Secretary of State any instances where the Committee feels these to be inappropriate or not properly consulted upon.

The H&WB Scrutiny committee noted the difficulties with engagement, and the reservations of GPs pending further evidence that was now available. They also noted the support of NDDH, and the finding of achieving 97 avoidable hospital admissions (calculated on the basis of previous levels of activity). The committee moved to note the report and requested progress reports in 6 and 12 months.

STITCH has submitted a review of the 6 Month evaluation and provided 39 appendices and 17 "patient stories" as evidence, which include submissions from carers and observations, some of which are outside the period of the test of change.

STITCH has concluded that the four "Nicholson" tests for the NHS have not been met, namely: support from GP commissioners; clarity on the evidence base; strengthened patient engagement and consistent with current and prospective patient choice. In a report and a public meeting, STITCH declared that the evaluation as not valid, demanded that the pilot cease with the inpatient beds being reinstated, and requested that the community works with the CCG and NDHT to develop a tailor-made healthcare plan for Torrington. I have summarised the key messages and themes from the reports and supporting papers in Appendix E and F.

Draft Evaluation

The latest draft of the evaluation report concludes that the new model of care has demonstrated its objectives of being safe, sustainable and of quality (equal or better than before). It is understood that if the evaluation shows that there is no negative impact on the local health system, and if it is shown to be safe for patients, offers them a quality service, and is sustainable (affordable and can be resourced in staffing) then it will continue in Torrington. There is also an understanding that this model will also be considered for the whole of Devon. Therefore the evaluation, in terms of its design, method and conclusions, is of critical importance to local residents of Torrington and beyond. The Evaluation report is to be considered in conjunction with the engagement report, in the way that the two reports were combined and summarised for the Health and Wellbeing Scrutiny Committee.

6. Review of the Evaluation Report

The published and agreed objectives of the Torrington model were to be safe, sustainable and of quality (equal or better than before). Therefore there is a requirement to compare the current model with the previous service, and demonstrate the impact of the change. There is no evidence of a systematic review or appraisal of the community hospital inpatient service before the change to enable a comparison to be made.

The evaluation report considers the service activity, cost and outcome of engagement in order to help to demonstrate whether the model is meeting its objectives. The design of the evaluation was set out in an Evaluation Framework *(Reference 7),* and data was matched to demonstrate compliance with certain domains in the NHS Outcomes Framework.

The hypothesis stated in the evaluation report 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.*"

The evaluation framework was designed to assess the impact on the whole health and care system and so focused on collecting routinely available data on health and social care activity and finance providing a basis for quantitative analysis. The views and experiences from those affected by the change were collected through a questionnaire, public events, case studies and interviews and these provided the basis for qualitative analysis.

The evaluation report is in draft form, and in response to sharing with groups such as the oversight group, it has been developed and additional data included.

I have analysed the evaluation report by commenting on each successive question and section.

The report poses six questions, and following this includes sections on aspects of the evaluation such as engagement and standards.

1. Have Torrington patients been disadvantaged through the absence of Torrington community hospital beds?
2. Has the community team delivered an enhanced service?
3. Are the patients and carers happy with the service they received?
4. What are the financial implications of the model?
5. What are the service standards and how do they compare with the previous model of care?
6. What are the challenges of delivering care in the community?

1. Have Torrington patients been disadvantaged through the absence of Torrington community hospital beds?

Measures have been taken on the impact on the closure of the beds and the provision of enhanced community care over a 6-month period. During equivalent six month periods 56 patients (2011/12) and 45 patients (2012/13) had their care in a community hospital bed. It is understood that around 36 (70%) of those would have been transferred from Barnstable hospital following an operation or illness, and would have been admitted for further care, rehabilitation or end of life care.

The questions asked concern the impact of the bed closures on the general health services, to determine whether there were unforeseen consequences or patterns of service use that would illustrate difficulties within the system.

These questions were framed in the evaluation framework as matching objectives, and this selection was included in the evaluation workbook report. I have reproduced the findings in summary form and added comments in order to aid my understanding, re-present the data and test the findings. In order to increase an understanding of the data, its source and the analysis I have labelled the table and the data, shown the source of data, and clarified the time periods for the data. The table therefore stands alone with an audit trail that may help increase confidence in the robustness and accuracy of the figures.

No	**Measures of whole system**	**No. Patients Oct 2011 /Mar 12**	**No. Patients Oct 2012 /Mar 13**	**Baseline No. Patients** (Average of last 2 years of same 6 month period)	**ToC No. Patients Oct 13 – Mar 14**	**Difference %**
1	An increase in A/E attendances?	1051	1186	1119	1151	3%
2	An increase in emergency admissions to the DGH?	700	719	710	636	-10%
3	An increase in attendances at the neighbouring minor injuries units? (Bideford)	222	195	209	184	-12%
4	More Torrington residents being admitted to other community hospitals?	56	45	51	26	-56%
5	An increase in telephone calls to the out of hours services?	864	816	840	773	-8%
6	An increase in calls to the ambulance service (for 65 and over)?		249	249	237	-5%
7	An increased length of stay at NDDH because there are no community beds to come to - bed days?	3.7 days	3.4 days	3.5 days	3.9 days	11%
8	An adverse effect on end of life care?		42	42	35	-17%

Table 1: Measures of Impact of Test of Change on Whole System for Torrington Residents (registered with GP practice and EX38 postcode) Source: Evaluation Report with data from HES and SUS

The CCG analysis of the changes in activity has been calculated on a baseline that is an average of the previous two years for the same 6-month period (column 5 in the table above). This methodology was adopted to take account of variations in the previous

two years. However, the method carries the risk of masking trends over the three-year period, and creates a potential difficulty in referencing data and auditing the activity.

There has been a marginal increase in A/E attendances, although there may be many factors that could have affected this activity and this activity reflects the usage by patients of all ages in the community, and not just the cohort of patients who would have been accessing the TCH inpatient beds, namely older people. This is understood to be consistent with the rest of the Northern locality.

The attendance of Torrington residents at Bideford minor injuries unit has remained fairly stable, and shows that 11 less patients attended in 2013/14.

The admissions to community hospital beds for Torrington patients were 56 in 2011/12 and this number dropped to 45 in 2012/13. A case mix analysis with lengths of stay would provide more detail regarding the complexity and dependency of patients over this period. 26 patients were admitted to community hospital beds during the six-month test of change, suggesting that if activity was consistent with previous years, between 19 and 30 patients would have been treated elsewhere (either DGH or at home). The CCG analysis worked on a baseline of 51 patients (the average of 2011/2012 and 2012/2013) which indicated that possibly around 25 patients were treated elsewhere. These figures are indicative rather than absolute as they are calculated on an average of the previous two years.

The calls to the GP out of hours service was 864 in 2011/12. Activity reduced to 816 in 2012/13 and increased to 840 in 2013/14. Annual variations are to be expected and again may be subject to different factors. There were no additional calls on the ambulance service involving older people, as demand reduced by 5%. The number of people requiring end of life care was less in the period of the test of change (35) than in the previous equivalent period (42).

The average length of stay of Torrington patients in the NDDH increased. In the six-month period in 12/13 it averaged 3.4 days and in the test of change period it averaged 3.9 days. Given the role of the TCH in providing step down care, this increase may have been expected.

Not included in the evaluation but would contribute to the understanding of the changes inpatient flows was the number of hospital bed days for patients from Torrington during the TOC. This was in the spreadsheet of the evaluation framework results and shows a reduction in bed days by over 50% in community hospitals and over 20% in all hospitals. I have summarised these results in the table below.

Bed Days for Torrington Residents	**Baseline No. Patient Bed Days** (Average of last 2 years of same 6 month period)	**ToC No. Patient Bed Days** 6 months Oct 13-March 14	**Difference No Bed days**	**Difference % of bed days**
Occupied bed days for Torrington residents in community hospitals	1535	707	828	-54%
Occupied bed days for Torrington residents in all hospitals	4028	3180	848	-21%

Table 2: Measures of Impact of Test of Change on Whole System for Occupied bed days for Torrington residents (registered with GP practice and EX38 postcode) Source: Evaluation Report with data from HES and SUS

The evaluation report concludes that there was no adverse impact on the local health system from the closure of 10 community hospital beds, based on the activity analysed. Table 1 shows that the number of emergency admissions reduced by 10% (74 patients) which is a positive impact.

Question 4, regarding Torrington patients admitted to other community hospitals, merits a further breakdown and requested data has been provided by the CCG to clarify the use of other community hospitals during these periods.

Community Hospital	**Baseline No. Patients** (Average of last 2 years of same 6 month period)	**ToC No. Patients** 6 months Oct13- March 14	**Difference %**	**Comment**
Torrington Hospital	40	3	-92%	Beds opened temporarily during TOC
Other Community Hospitals	11	23	109%	Doubled the use of other CH beds
Total	51	26	-49%	Half patients in inpatients beds compared to baseline

Table 3: Comparing the number of Torrington Residents having an inpatient stay in a community hospital over the two time periods

More Torrington patients are now having their inpatient stays in other community hospitals than in previous years. It is recognised that Bideford (about 15 minutes by car) and South Molton (about 30 minutes by car) offer specialist services that local people would be referred to in preference to beds at Torrington hospital.

Other Community Hospitals	**Baseline No. Patients** (Average of last 2 years of same 6 month period)	**ToC No. Patients** 6 months Oct 13-March 14
Bideford (offers stroke service)	7	12
South Molton (offers Consultant beds & orthopaedic)	3	5
Holsworthy	1	6
(Torrington during TOC)		3
Total	11	26

Table 4: Comparing the use of other community hospitals by Torrington Residents having an inpatient stay in a community hospital over the two time periods

The data suggests that 9 patients required a generalist community hospital bed during the period. Of these 6 who went to Holsworthy and 3 who were admitted to the Torrington beds when they were opened temporarily.

Tables 5 and 6 show the actual admissions over the three six-month periods, rather than comparing the test of change period to an averaged baseline. This allows a clearer comparison with actual and known patient admissions.

Community Hospital	No. Patients Oct 11-Mar12	No. Patients Oct 12-Mar 13	No. Patients Oct 13-Mar 14
Bideford	11	3	12
South Molton	4	2	5
Holsworthy	1	1	6
Torrington	40	39	3
Total	56	45	26

Table 5: Community hospital admissions by Torrington residents over the corresponding six month periods

It has been noted by the CCG analyst that the admissions in the six month period 2012/13 to Bideford hospital was less than anticipated, based on the typical demand for stroke care. In broad terms, the table shows a reduction in the admissions to community hospital beds by Torrington residents by about half. The evaluation report includes the case note review undertaken of 10 Torrington patients who were admitted to a community hospital bed from NDDH over the first four months to assess appropriateness and implications. The summary of the case note review in the evaluation does not detail which community hospitals these patients were admitted to and why. However it is understood that patients requiring stroke care are typically referred to Bideford and those requiring orthopaedic and other specialist care are referred to South Molton. There was no indication in the case note review of inappropriate admissions regarding specialist need, and the use of community hospitals outside Torrington will continue to be audited and monitored. It is understood from the NDHT analyst that the increase activity in the community hospitals was absorbed.

It would be helpful to know the previous full years admissions, as annual activity is the usual measure used. Extrapolating the six months to a full year, it can be seen that between 90 (12/13) and 112 (11/12) Torrington residents could have been admitted to a community hospital inpatient bed and that of those between 78 (12/13) and 80 (11/12) would have been admitted to TCH. Therefore it may be projected, based on past activity, that around 80 older people a year, who would otherwise have been admitted to TCH, will now be either cared for in their own homes, be admitted to other community hospitals, be admitted to a nursing home for an episode of care, or have a prolonged stay in NDDH.

Community Hospital	No Patients Oct 11-Mar 12	No. Patients Oct 12-Mar 13	No. Patients Oct 13-Mar 14
Bideford	11	3	12
South Molton	4	2	5
Holsworthy	1	1	6
Total	16	6	23

Table 6: Admissions by Torrington residents to neighbouring community hospitals over the corresponding six month periods

Table 7 shows the increased use of alternative places of care, and has extrapolated the six-month activity to annual predicted activity. This is based on assumptions worked through with the NDHT analyst and CCG. This was based on the following analysis of the 6-month period of the test of change and is summarised in the table.

Place of Care	Last 6 month period	TOC period	Increase	Extrapolated to annual projection
Holsworthy (& including 3 TCH patients in TOC)	1	9	8	16
Nursing home (spot purchased)	1	6	5	10
Home care (assumption)		+20%	27	54
Annual Total			40	80

Table 7: Changes in place of care, from six-month additional activity to alternative place of care and extrapolating to annual activity

- An increase of 8 inpatient admissions to other community hospitals for patients needing generalist community hospital care in the TOC. This calculation has been made on the basis of 6 patients to Holsworthy and 3 to TCH. The increase is 8 (9-1) as previous activity was 1 patient to Holsworthy and gives an annual projection of 16.
- There was an increase of 5 patients in the six-month period to spot purchased nursing home placements, (6-1) giving an annual projection of 10.
- A 20% (2000) increase in community visits suggesting around 27 were cared for at home (avoided admissions) giving an annual projection of 54. Part of the increase in community visits may also be attributed to a projection of around 148 patients cared for at home through the enhanced service who otherwise would have been admitted to NDDH (710-636) during test of change, doubled for full year).

It would be helpful to have a commentary on the impact of the increased number of patients being admitted to other community hospitals.

The question being asked in this section is whether Torrington patients have been disadvantaged through the absence of Torrington community hospital beds. The response to this section focuses on the numbers of patients rather than how this has impacted on them.

Around 40 patients would have been admitted to TCH over the six month period, and the activity shows that in the test of change when the beds were closed there was an increase in admissions to Holsworthy community hospital, more use of nursing home beds and an assumption that more patients being cared for at home. Given the small number of patients concerned and the identifiable cohort of patients, it may have been possible to carry out a review of patient pathways to determine whether patients had been disadvantaged by the loss of the inpatient beds. This could have been part of an independent evaluation.

A number of the 17 patient stories submitted as evidence through STITCH illustrate some difficulties experienced by patients and carers, with examples such as transport and access problems for patients in Holsworthy hospital particularly for end of life care (Appendix F). These are being investigated by NDHT.

In order to inform the discussion on the practical implications of patients being cared for in community hospitals outside Torrington, I have been supplied with information from individuals within the community on travel distances, times and costs. I have summarised some of the data in table 8 below.

Community Hospital	Postcode	Distance (miles)	Travel by Car (minutes)	Taxi from Torrington one way	Buses
South Molton	EX364DP	15	33	£59	5.5 hours travel time for one hour visit
Holsworthy	EX226JQ	16	35	£63	Nearly 6 hour travel time for 25 minute visit (no buses Sunday)
Bideford	EX393AG	8	14		

Table 8: Travel distance, time, taxi costs and buses for Torrington residents accessing other community hospitals. Source: Submission from members of the public.

I have received submissions that have pointed out that public transport to Holsworthy and South Molton is problematic, requiring changes of buses and waits for connections. Those commenting on patients now having their inpatient stay at Holsworthy for instance are concerned about the logistical problems of travel, particularly carers wanting to visit who are frail and elderly. They are also concerned with costs and being financially disadvantaged.

Some patient stories also express concerns about the reliability and expertise of community nursing staff in offering home based care (Appendix E & F). These patient stories are being investigated by NDHT in order to find out more about the experience, pursue as an official complaint if that is appropriate, and attend to service improvements as required.

In respect of assessing the impact of the change on individuals, the CCG organised a case note review of 10 Torrington residents who had an admission into a community hospital bed outside Torrington, and also of 6 patients who were receiving home care who may otherwise have had a community hospital admission during this period. The case study review of the patients in community hospital beds outside Torrington showed that admissions to a community bed was appropriate in all cases, and described the cohort of patients as frail older people who were often close to their last illness. The case note review concluded that the care was safe and effective, and noted that consultant oversight was required. The case note review also concluded that for patients having community hospital inpatient stays the service was inconvenient. The evaluation recorded that triangulation was yet to be carried out and that there was more data to come.

Although this question asks about patients being disadvantaged, there may have been scope within the workbook to identify patients who were now benefiting from the increase in services within TCH such as diagnostic ultrasound and an increase in day treatments. A timetable of current, new and planned services for Torrington Community Hospital is provided on the website, and I have reflected this and developed it further in Appendix B.

It is acknowledged within the evaluation that given the small numbers and short timescale it is difficult to discern a trend. The question being asked is whether Torrington patients have been disadvantaged by the lack of beds in Torrington community hospital. The analysis concerns the use of health services by the whole community, and not focused on the experience of the cohort of older patients who would otherwise have used the beds. There are many variables that will affect the utilisation of health services by the whole community over this period which are acknowledged. These would include factors such as a flu outbreak, a mild winter etc.

Therefore it is not possible to be confident about cause and effect of the closure of the beds as a single factor. It is reasonable to demonstrate cause and effect however in respect of the closure of the beds which resulted in an increase in the need for home-based care and an increase in the utilisation of other community hospitals.

2.Has the Community Team Delivered an Enhanced Service

Table 9 shows the increase in the frequency of visits to patients in their own homes.

Community Home based Care	Baseline	ToC Period	Difference	%
Total Visits	5669	7760	2091	37%
No of Patients	449	460	11	2%
Staff Did Not Attend (missed visits)*	0.12%	0.05%	-0.07%	-58%

Table 9: Activity of community home-based care during the baseline 6 months (average of 2011/12 and 2012/13) and the test of change period.

**Figures on staff DNA supplied on request to help answer concerns regarding reliability and capacity.*

The evaluation report shows that the number of visits to patients within their own homes increased by over 2,000 over the 6 months (37%). The number of patients on the community caseload for the community team increased marginally (11 patients) although there are fluctuations in the numbers of people requiring healthcare at home.

It is noted that there has been an increased in community-based staffing over the past few years, and that this was 12 whole time equivalents in 2011/12, 17 in 2012/13 and 22 in 2013/14 (rounded). Therefore the most significant staffing increase was in 2012/13.

Feedback from some of the patient stories submitted by STITCH indicate an issue with the quality of home care and the reliability of the visits by community staff. Data is regularly recorded such as any missed or late visits, and requested data on this in the table shows that the overall compliance with meeting planned visits is being maintained.

The increase in patients supported at home was 11 and this 2% increase (11 patients) is typical for demographic growth and as such is most likely to represent an increase population of elderly people requiring support. The CCG has noted that patients may be on the community caseload, be counted in hospital admissions, and may return to the caseload on discharge for further support.

The CCG and NDHT have indicated that the comPAS recording systems for activity used by community staff is routinely used now to manage workload and activity and there can be confidence in the reliability of the data.

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

The evaluation report *(Reference 1)* summarises the outcome of some of the stakeholder engagement. To answer the question of whether patients and carers are happy with the service, the report records that there were 28 NHS Friends and Family test (FFT) forms completed by patients receiving community therapy (none from community nursing).

This was a 16% return on patients receiving community therapy services and a very small proportion of patients receiving home care overall. Patients completing these forms gave a positive score to the question of whether they would recommend service to friends and family (+75). A further survey was instigated and produced the same result (+75) although it is not stated how many patients and carers completed the second survey. The evaluation also includes quotes from patients describing their positive experience of home care having been interviewed by the communication team although it is not clear from the main report how many patients were interviewed and how they were selected. Appendix 5 includes six patient stories, and describes the process that involves patient/carer sign-off and validation by Healthwatch. There is a case to be made that patient/carer interviews themselves may be best carried out by an independent agency, although there the interviewer was someone who was not directly involved with the patient's care.

The Torrington Community Cares website has been used to provide access to the public to information, resources and reports, which is to be commended. The website includes patient stories in the form of a narrative and also videos. The selection of stories used to inform the community may have been undertaken in order to provide some "balance." However, some of the patient experiences alert to real problems with the service such as patients having to repeat information to everyone coming to their home, and carers feeling unsupported. One of the videos presents these difficulties and then concludes with what the team are doing to address these problems. However, there is a risk that those watching the videos will lose confidence in the service, and may not watch the video to the end to see how the issues are being redressed. It is understood that the way that the material has been used has been questioned in writing by an interviewee.

The section on patient and carers satisfaction with the service in the evaluation report workbook needs to be read alongside the Engagement Report which sets this out in more detail. Cross-referencing between the two documents would be helpful as currently they do not stand-alone.

7. <u>What are the financial implications of the model?</u>

In order to demonstrate if the service is sustainable, at least financially, an analysis has been made of the cost of the new model of service (section 10).

The financial analysis shows an overall saving of nearly £250K per annum. This is from saving £549k from the closure of the beds, and an estimated £80k saving from the reduction in unplanned admissions, offset by an increase in revenue for community-based staff is given as £383k.

This is high level and illustrative. Given that the closure of the beds have been shown to impact on other community hospitals and to placements in nursing homes, it may be expected that this may need to be reflected in the financial assessment. I have been advised subsequently that spot placements in nursing homes has increased from 1 placement to 6 placements over the test of change period with an increase in cost from the previous period from £2k to £17k. This will need to be reflected in the calculations and another other cost implications.

Financial Assessment	£'000
Total inpatient direct costs saved	-549
Additional community funding	383
Savings from reduction in acute admissions	-80
Net Savings	-246

Table 9: Financial assessment of test of change implications

The evaluation report presents the assumptions on the potential savings from avoiding 74 emergency admissions. It is suggested that additional costs such as from spot-purchasing additional nursing home beds should be taken into account. I have been advised that this is in the region of an additional £15k for the six-month period (£2k for the previous equivalent period, and £17k for the six month test of change). Even taking this into account, the calculations indicate that the enhanced community service will generate savings, which has been used to make the case that the Torrington model will be sustainable.

The calculations appear to indicate that the building would continue to be available and there has been no specific allowance for additional services within the hospital, either at a cost as a new service or as an income if a hosted outreach service. The overall costs of health and care services may need to be taken into account. If assessing the use of local health and social care resources in previous model (community hospital inpatient beds) and comparing this to the test of change model (enhanced community nursing) there may be a need to include the costs of all of the services involved. Therefore it may be helpful to identify usage of spot purchased nursing home beds before and after, as well as the costs to other community hospitals, and translate this into a financial cost to the local health economy.

Evidence from patient stories submitted by STITCH make the point that there are cost implications to patients and families when community hospital inpatient care is provided outside Torrington. Travel costs are incurred for instance.

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

NDHT staff have noted that other measures of sustainability are operational, such as staff recruitment and retention, access to required equipment for home care etc.

5. What are the service standards and how do they compare with the previous model of care?

This is an opportunity to measure the service before, and compare with the new model to determine whether there has been an improvement in the service to patients.

However, there is no information given in the report or elsewhere that I have found that reviews the service provided in community hospital. It would have been of interest to understand case-mix and acuity, any improvements to patients during rehabilitation with regard to functionality, number of complaints and compliments etc.

The key measure used in the evaluation report to compare the two services in respect of service standards and quality has been to record the qualifications of nursing staff

which is a very narrow focus. Although not quantified, it would appear that some community nurses have reached a level of community nurse practitioner degree. It would be useful to know how this compares with the qualifications, experience and training of community hospital staff.

This section on service standards is in the form of discussion rather than evidence, and makes a point that community nurses have a larger case load than community hospital staff and therefore can maintain their skills. However for balance it may also be added that that community hospital staff experience a continuity of patient care over an inpatient episode that requires 24/7 care, which also requires skills and experience.

To focus on the qualifications of staff arguably does not fully answer the question being raised about overall service standards. It may have been helpful to have incorporated the views and experiences of staff regarding their practice so that an account could have been taken of those delivering and the care. There may also have been an opportunity to assess a selection of patients and assessed their experience and outcome of the service. Measures of service standards are typically on provider dashboards, and may be incorporated more fully.

Overall, patients have commented that the service has reduced from a 24/7 service in the hospital, to the hospital being open Monday to Friday during office hours, and homecare available 8am-8pm. Access and availability of the service is therefore a consideration.

6. What are the challenges of delivering care in the community?

This section links to the paper on evidence about home care. The paper compares the experience of those nursed at home to those nursed in a large general hospital. The paper identifies the increased risks of infections, falls and institutionalisation. The remainder of this section is in the tone of a discussion and presentation of views, rather than an evaluation of facts or experiences.

Challenges and concerns raised by STITCH in their evidence include the challenge of staff recruitment and retention, being able to cover the geographic patch, travel times and general access. This section discusses potential arrangements for visiting people at home with regard to travel arrangements and weather. There is scope to expand this section given the very real concerns expressed by the community.

Section 13 Healthwatch, Devon Senior Forum, Torrington Town Council and the Northern Locality Questionnaires

The evaluation report refers to engagement activities prompted by the community such as Healthwatch (questionnaires), Devon Senior Voice (questionnaires), Torrington Town Council (open door sessions). The results of these engagement activities are not given in the evaluation report. The only measurable outcome included in the evaluation report is to note that 64% of responses identified a wish for beds to remain in Torrington hospital (page 32), although it is not clear what question was being answered and which survey this was. It would have been helpful to provide a table setting out the scale of the surveys and key outcomes and I have indicated some of this data in Table 11. There is an opportunity to refer to the extent of the engagement and cross-reference to relevant documents.

Survey	Numbers	Suggested Key Outcomes
Meeting Local Needs CCG	211	68% of respondents wanted beds at the hospital when asked what services they would like
Torrington 200 Healthwatch	167	Concern about the beds, wanting clarification on enhanced home care, and concern about social isolation for older people supported at home
Devon Senior Voice	52	Support for local community hospital beds Just over half think that community beds are better than home care for older single people
Parish Poll Torrington Town Council	1380	99% voted to keep inpatient beds at TCH
STITCH public meetings	200+	Support for the community hospital and the beds
STITCH Patient Stories	17	3 themes identified and being investigated: • Difficulties in getting an inpatient bed at TCH • Problems with a lack of access to TCH beds • Difficulties with enhanced community care

Table 11: Surveys and Polls associated with Torrington Model Test of Change

It is understood that the CCG has some reservations about the framing of some of the surveys initiated from the community, and this will need to be clarified.

Section 14 Views of the GPs Consultant Geriatrician and Senior Community Clinical Staff

The evaluation report captures views of clinical staff through a process whereby a team of clinicians carried out a case note review of 10 patients having community hospital care during the test of change. Some clinicians who took part in the process said that they were not always clear about the criteria being used. It is assumed that the assessment of each patient experience was undertaken to determine whether the care was appropriate, safe and effective. The evaluation report refers to the fact that the results have yet to be verified and triangulated.

For many community hospitals, the case mix of patients is typically frail older people with co-morbidities, who require rehabilitation following an illness (such as UTI), an event (such as a fall) or a procedure (such as joint replacement). Patients may also be admitted for end of life care in many community hospitals. It is understood that the proportion of step up (directly from GPs) was understood to be 30%, and step down (from NDHT) was 70%. It may be that there are patients with long-term conditions who are receiving continuity of care. It would be helpful to have a casemix analysis and acuity analysis of the use of the beds.

Conclusions of clinical staff included that it was inconvenient for patients needing a community hospital bed to be cared for outside of Torrington, and that the care was safe and clinically effective. Subsequently 6 case notes of patients having home care were reviewed, and among the findings it was noted that all lived alone and all remained at home after the treatment programme.

This section concludes with some general conclusions about the new model of care, indicating that there was a consensus by clinical staff that the care was safe, although noting that for some patients who would otherwise have gone into Torrington community hospital beds, will be less convenient.
There is scope to widen this section to capture views of staff including medical, nursing and therapy staff regarding their views and experiences of delivering care in the previous model and comparing it to the new Torrington model.

15. Summary of Evaluation Report

The evaluation report combines findings from service activity analysis, financial analysis and views of some of the patients concerned. The report concludes that the evaluation has demonstrated that the Torrington model is safe, sustainable and of equal or better quality than before. It would be helpful if there were a more direct link to make it clear which source of evidence is being used to demonstrate this.

The conclusion is reached by summarising key findings in the report such as "cost effectiveness", "more productive", "excellent feedback from Friends and Family test", "less exposure of patients to risk or institutionalisation in hospital" and "no negative impact on overall health or social care system." It is suggested that in the next version of this report, a clearer link is made between the conclusions reached and the evidence used from within the report to substantiate the findings.

There is also a case for putting in place a system for validating further data and evidence being collected and analysed, which may include an independent assessment.

Conclusions of the Evaluation Report	**Evidence to Support Finding** (To be completed in subsequent version of the report)
As good or better in terms of health and social care outcomes than before	
Safe	
In receipt of excellent feedback from patients through the Friends and Family test	
Demonstrates no negative impact on the local health and social care system of Torrington and its parishes, or further afield in Northern Devon	
More cost effective than the direct comparison to the cost of the beds	
More productive in terms of community services available	
Reduces exposure to risk in hospital and creates less institutionalisation of elderly patients	

Table 12: Summary of Evidence to Support the Evaluation Findings

Table 12 shows how this may be systematically presented for ease of reference.

The evaluation of the service provides the basis for a recommendation to the Health and Wellbeing Scrutiny Committee (Reference 4 and 42) and Joint Boards Report (Reference 3) to implement the Torrington model.

The Chief Executive of the NDHT, in her letter to Torridge District Council (Reference 41), summarised key findings of the evaluation as follow:

"The evidence of the new model of care is compelling. In six months:
- *97 patients were supported in their own home to avoid a hospital admission*
- *10% fewer patients were admitted to NDDH as an emergency*
- *The length of stay in hospital was reduced from an average of 35 days to 7days.*
- *There were no statistically significant changes to numbers of phone calls to Devon Doctors, SWAST, 999 or visits to local MIUs."*

With regard to the first point, it may be helpful to clarify that the figure of 97 patients refers to a prediction of the number of people who would otherwise have gone into hospital based on past levels of activity, rather than actual known patients. Activity over this period may have been affected by other factors such as a mild winter or demographic changes which means that this figure could have been higher or lower.

The length of stay reductions are explained by patients staying slightly longer in NDDH but then going back home, as opposed to having a shorter stay in NDDH but then having a stay potentially of 2-3 weeks in a community hospital.

The letter to Torridge District Council provides a useful summary of the findings of the evaluation and the current position of the NDHT.

8. Review of the Engagement Report

The Engagement Report *(Reference 2)* sets out the engagement activities and includes a critique of the engagement process. There are 16 supporting appendices that detail aspects of the engagement *(References 12-27).*

The question being asked in the formal document launching the public engagement, entitled "Meeting Local Needs" *(Reference 31)* is: *"What should the role of Torrington Community Hospital be in the future, for the greatest benefit of people in and around Torrington?"*

The engagement report describes 12 different methods of engaging with all stakeholders with a stated objective of keeping the community informed such as drop-in sessions, workshops, survey, interviews, meetings etc. Processes include the creation of the Oversight group involving stakeholders.

The "Meeting local needs" document asks:

- What services and support would you like to see provided at the hospital?
- What needs would these meet?
- What in your view would successful home-based care be like (generally or for individuals) in the Torrington area?

These are all open questions, so analysis presents a challenge. The engagement report summarises findings and shows that of the 211 replies to the question of what services you would like to see at the hospital, 144 *(68%)* responded with the answer "beds" and 48 said that they wanted to keep the hospital open.

The report describes the community campaign group that has been formed (STITCH - Save The Irreplaceable Torrington Community Hospital) and the action that they have taken concerning further engagement such as through public meetings, a parish poll, questionnaires and collecting accounts of the experiences of patient and carers. These activities are listed, and detailed outcomes reported in accompanying documents. Additional surveys such as those led by Healthwatch, (the statutory consumer champion) and the Devon Senior Forum are also referred to.

The Healthwatch report states that three concerns appear of major significant as a result of this work which are that "we don't want the beds re-located", "what is understood by enhanced home-based care?" and "How will people's safety and social isolation be dealt with if more people are cared for at home?" An appendix to the Engagement Report details a response to each of the recommendations made by Healthwatch.

The Healthwatch report also records that: *"There is a tangible perception by our respondents…that the public engagement process is a pretence, that a decision to permanently remove the inpatient beds has already been made and is a precursor to closing the hospital. Moreover, there is a suspicion that this decision is being driven by financial pressures. There remains, however, mistrust by some local people of the CCG and NDHCT and this is impeding a constructive dialogue about future healthcare in the Torrington area."* Healthwatch Torrington 200

It is not clear how these issues are addressed within the evaluation of the service, in order to help build confidence in the service.

The engagement report cites the flexibility in the process, showing how the process adapted over time, and is explicit about limitations in the process. There is a clear critique of some of the shortfalls in the engagement process.

The report has yet to provide any guidance on how to incorporate the views of stakeholders into the evaluation, nor does it provide any recommendations or conclusions to contribute to the overall assessment.

As the engagement period has been extended to allow for local people to contribute their views, there will be an opportunity to revise the report to take into account more recent submissions. The invitation to submit views was made through various methods, including the website and local papers, saying that the NHS in Northern Devon wants to take more time to hear from local people about the Torrington Community Cares test of change.

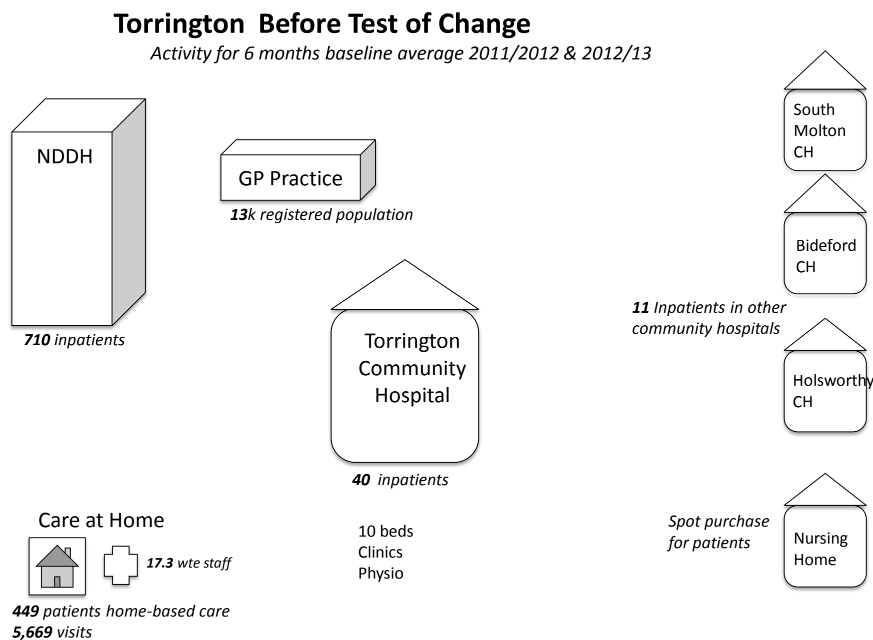
Therefore there is an opportunity to extend the engagement report to develop some conclusions and recommendations that can then inform the evaluation report.

9. Summary of Torrington Model in Diagrammatic Form

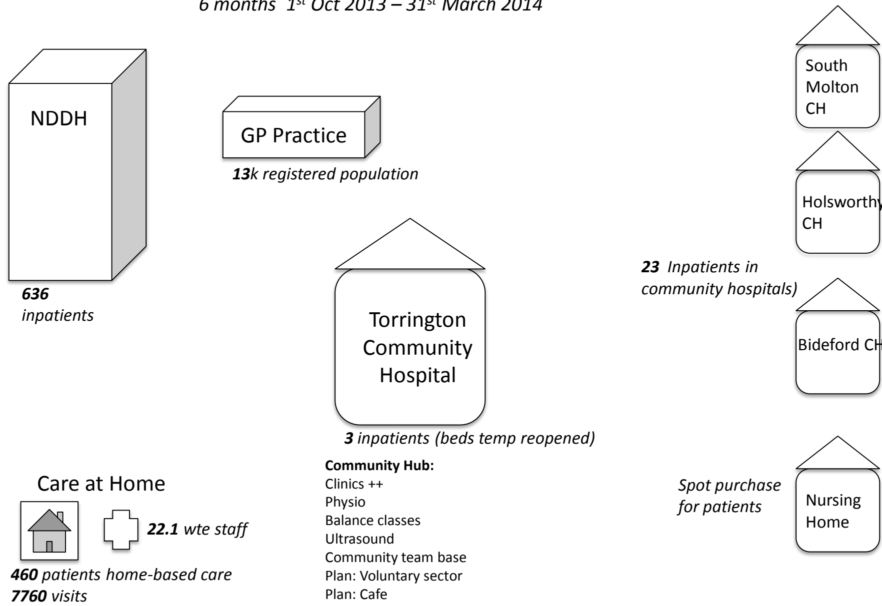
There was a comment in the Engagement Report that there was some difficulty in understanding the data that was being produced. This may have been compounded by the decision to create a baseline from an average of two previous years, and to use the 6 month period, and to present the data in a series of tables providing results from different time periods (8 weeks, 4 months and 6 months).

"Feedback from Torrington was that the information document and evaluation data was very difficult to understand. This lack of understanding fuelled the mistrust about the figures." Engagement Report

In order to try and understand the service before and afterwards, I have reproduced this information in diagrammatic form and checked this with the CCG for accuracy. The diagram below, which draws on data from the evaluation report, shows the main services activity before the change, which shows that there was some community home-based care, and 40 inpatient community hospital admissions in 10 beds in TCH as well as 11 admissions to other neighbouring community hospitals.



The service configuration during the test of change shows the 10 inpatient beds at TCH closed (although 6 opened temporarily during the first 8 weeks of the TOC, accommodating 3 patients). The diagram shows as increase in Torrington patients having inpatient stays in other hospitals (23). The diagram also reflect that data showing that more patients receiving more visits within the community. The activity also shows less emergency unplanned admissions to the North Devon District Hospital (NDDH) for Torrington residents than in the previous equivalent six months.



The diagrams show the shift of emphasis to an increase in home care and use of other community hospitals, and an increase in the use of the hospital building for additional services. Enhancements to the service within the hospital in the vacated ward areas, such as ultrasound and additional clinics, have not been specifically measured as a health benefit as part of the evaluation, although are illustrated on the TCC website.

10. Summary Table of the Review of the Evaluation and Engagement

The table below is a summary of the key points regarding what has worked well and what has worked less well. It has been designed for ease of reference and to illustrate the way that the review has been undertaken.

Process	What worked well	What worked less well
Launch of Torrington Model	Designed to be in keeping with national policy and good practice to support as many people at home as possible	Announcement of closure of the beds created a shock throughout the community
Preparation for Test of Change	Swift response to the possibility of a judicial review and delayed closure of beds	Community considered pursuing a judicial review, and formed a campaign group STITCH
Test of Change	Decision to test the impact of the change	Confusion regarding the nature of the pilot or test of change, as assumed if unsuccessful original service would be reinstated
Torrington Model	Model designed to increase access of many more local people to a range of services - such as ambulatory care and clinics in the hospital, a more integrated service with the voluntary sector, a continuation of using other CH beds for those that need them and more people cared for in their own homes with more visits over an extended time period (8am-8pm)	Lack of clarity in the model - viewed as the loss of a local 24/7 service with the inpatient beds to fund extra staff in the community. A view from clinicians and the community that the model was not "new," but rather an increase in existing home care.
Evaluation Design	Evaluation Framework reflects NHS Outcomes and matches data to objectives	Not designed early enough in the process and not co-produced resulting in a lack of confidence in the process
Independent Evaluation	A commitment by the CCG to have an independent evaluation of the model in addition to their internal evaluation, with options such as working with academic institutions such as Plymouth University.	No independent evaluation commissioned which is a limitation given the sensitivity of the change and the potential impact of closing community hospital beds.
Focus of Evaluation	Focus on enhanced community care in addition to the impact on the wider healthcare system	Expectation of each element of the TCC model being evaluated such as changes in inpatient experience and an increase in clinics etc. in TCH
Communication	A specific TCC website has been created with easy access to documents, information and offering ways of communicating views	TCC website needs updating, and includes some negative patient and carer experiences which may not help with confidence in the model
Baseline	The baseline being measured was the whole health system (A/E attendances etc.)	An expectation that there would be a clear articulation of the community hospital service with inpatient beds (status quo), a case made for change, and then a comparison with new model but this was not carried out.
Value	The CCG/NDHT describe the preference for patients to be cared for in their own homes and how the enhanced service will enable more people to do this	The community is concerned that the local NHS does not appreciate or recognise the value and trust that they place on their local community hospital and the importance and quality of community hospital care is not reflected in any of the key documents.
Integration	View of the future model of care is to increase integration across health and social care (teams based at the hospital), statutory and voluntary agencies (all based at hospital) and professionals working together	There is not a strong message about integration, compounded by the focus of the evaluation on one part of the service (enhanced home care) which is difficult to assess in isolation, particularly given the community's wider concerns
Evidence	A specially commissioned paper from Public Health to demonstrate the evidence base for enhanced home care	No analysis of evidence for all elements of the community services, such as community inpatient care, although the issue of patient selection indicates that some people will still need this service.
Comparator	Comparison made in whole system impact during 6 month period and previous 6 month period which was an average of the last 2 years	The method of averaging the two previous years activity for the equivalent 6-month period makes it difficult to track and audit activity, from known patient numbers to a constructed

		average.
Equality Impact Assessment	A recent EIA has been created by the TCC group and has been shared	The community is concerned that there was not an EIA before the change and believe that they have had to promote for an EIA to be carried out at this stage
Resourcing the Evaluation	Significant management resource allocated to the test of change	Management effort at times unfocused and raised expectations of input of engagement. Similarly the evaluation has prompted significant community activity and resources.
Independent Review	A commitment to incorporate an external assessor of the evaluation	Independent reviewer not appointed until 5 months after the end of the TOC
Creation of Oversight Group	Aimed to have representation across the organisations and the community, to oversee the evaluation, comment on it and make a recommendation	A lack of confidence from the community in the group, in the way it was constructed and operates
Management process	CCG and NDHT working together to manage the process, meeting regularly in their Tuesday/Thursday Torrington meetings which are well attended	There is a question of whether management time and expertise has been sufficiently focused- given this is described as an engagement exercise to inform the community and seek views but not a formal consultation
Start of TOC	Agreed to MP and community request to reinstate beds during the first 8 weeks of the TOC	Temporary opening of the beds caused confusion, with some evidence of local people being told that they were not available. Some confusion over the role of the beds as a "safety net."
Use of Data	Extensive analysis of whole system impact	The presentation of the data was considered to be confusing and needed to be interpreted within context of small numbers and short timescale
Current Activity	An analysis of visits (by urgent and planned) by enhanced community team	No analysis of activity to answer concerns such as completed visits/missed visits, complaints/compliments/ waiting times for services and equipment, readmissions etc. also no impact on other community hospitals.
Patient's Experience	Recorded Friends and Family Test forms of patients within the community which were positive (28)	Friends and Family test responses were very low (28/460). No measures of experience of patients who have had alternative care to TCH inpatients such as nursing home or care in other CHs
Review of Patient Episode	Clinicians carried out a case note review of 10 Torrington patients in community hospitals. They also reviewed case notes for 6 patients having home care who would have otherwise been admitted to hospital. The clinicians agreed on conclusions such as that the care was safe.	Unclear the report how the case note reviews led to conclusions made. Also how issues such as clinicians concern about patients in outlying community hospitals and recorded inconvenience was being addressed.
Cohort of Patients	Identification of the cohort patients for whom this change will have meant having their community inpatient stay outside Torrington	A cohort of patients (frail older patients assessed needing a community bed) are considered to be disadvantaged as they will have a CH bed outside Torrington or a nursing home bed and it is unclear what safeguards there are for these patients and their carers
Nursing Home Beds	Provision made for spot purchasing nursing home beds for older patients requiring 24/7 care	Data has only just been provided on the increase in the use of nursing home beds, and this has yet to be incorporated in the analysis. Also need to address whether spot purchasing is a sufficiently robust arrangement, as it is dependent on there being an available nursing home bed locally.
Patient Stories	CCG has interviewed 3 patients, and shared patient stories on the TCC website as narrative and videos - balanced view not all positive	STITCH has collected 17 patient stories contributed as evidence, showing issues with lack of access to CH beds and difficulties with home care

Engagement Design	Designed to be informative, with a question asked about the re-use of the hospital	Community unclear about whether they are able to influence the assessment of the TOC and in particular the reinstatement off the local beds.
Engagement Messages	Offering local people a range of ways of having their say, such as through letters, PALs, completing a survey on what services they would like at the hospital, and having conversations	Confusing messages, from "engaging to inform" to inviting people to "have their say on the reuse of the hospital" raising an expectation that this will influence any decisions
Engagement Activities	Extensive engagement activities including meetings, interviews drop-ins etc. so lists of many conversations with communities and organisations	Extensive engagement has increased expectation that the public view will count in the overall assessment of the model. This has yet to be fully reflected in the evaluation report
Engagement Presence	CCG/NDHT presence at key public evenest initiated by the community	Public prompted to initiative events to create a forum for discussion and capture views and concerns of local people collectively
Engagement Outcome	211 responses to Meeting Local Needs question	Responses to Meeting Local Needs question not yet adequately captured in the draft evaluation and engagement reports
Wider Public Engagement	CCG and NDHT cooperated and supported additional engagement activities prompted by the community and community organisations (Devon Senior Voice, Healthwatch etc.	The Evaluation and the Engagement Reports do not adequately reflect the outcome of the surveys carried out by community organisations such as the Parish Poll, Devon Senior Voice, Healthwatch and notes at public meetings.
Consultation	Specific decision to engage rather than consult	No formal consultation although it may be deemed that there has been a significant change of service (closure of beds)
Health Overview and Scrutiny	CCG/NDHT has continued to work with the Health Overview and Scrutiny Committee to keep them informed and gain support. The committee noted the Final Report on Engagement and Evaluation in June 2014 and has requested progress reports.	HOSC has a responsibility to ensure that the process adopted is appropriate. The reports are still being finalised.
Report on Evaluation	Report has been written in an evolving way, in communication with oversight group, and incorporating requested changes and additions (Version 11)	Report is still in draft form and has yet to fully reflect the work carried out to date, and fully address the questions and issues raised. Scope to be clearer about how the evaluation has proved the objectives and how this leads to a recommendation.
Evaluation Phases	The evaluation report sets out the findings in the phases of the evaluation (8 weeks, 4 months and 6 months)	The presentation of the data in separate timescales is confusing for the later version of the report and could now be simplified, with detail of changes over the period referenced in working documents
Report in Engagement	This report describes the extensive engagement activities and is clear about the times and dates of activities, and also includes a critique of the engagement process.	The report is not comprehensive, does not include the wider engagement activities led by the community/Healthwatch etc., does not capture outcomes sufficiently and has yet to make recommendations
Decision-Making	Joint Report to CCG/NDHT has been prepared and a recommendation for the Torrington Model. Agreement to defer.	The MP and community has requested a deferment of this report with recommendations until all evidence has been submitted, the evaluation is complete, and the independent review has reported.
Additional Evidence	The CCG/NDHT agreed to an additional 21 days for the submission of further evidence which has been widely publicised	The community, through STITCH, has carried out a significant amount of work to comply with the CCG.NDHT process of submitting patient stories, and assembling their evidence of 39 appendices supporting a main report
Next Steps	An opportunity to redraft both the Evaluation and the Engagement Report to make them more comprehensive, accessible, informative and evidence-based	MP has suggested "signalling a change" as there has been a breakdown of trust between those receiving the service and those paid to commission and provide the service.

11. Key Messages. Lessons and Recommendations

The table in the previous chapter details what has worked well in the evaluation and what has not worked quite so well. This chapter highlights key messages from the review of the evaluation.

The recommendation from the CCG/NDHT evaluation report is to support the Torrington model which is enhanced home care, permanent closure of Torrington community hospital inpatient beds, and re-use of the hospital as a hub for clinics and ambulatory care and other associated health and social care services. This is on the basis that the evaluation carried out by the CCG/NDHT has demonstrated that the service is safe, sustainable and of equal (or better) quality to the previous service.

Key Messages

The evaluation has concluded that the data has shown that the closure of 10 beds has not had a negative impact on the whole system of health and social care in Devon. The service has been shown to be financially cheaper than the previous model. Tests of quality have included some patient interviews and the Friends and Family Tests, which have illustrated the appreciation of home based care for some patients.

However there is a disconnect between what the CCG and NDHT want to evaluate (home-based care), the question being asked of the local community (the future re-use of the hospital) and what local people want to voice their opinions on (retaining their local hospital with inpatient beds). The community group STITCH has formally requested that there is a process for the community to be proactively involved in designing a tailor-made healthcare service for their community (Appendix E).

It may have been useful to consider the steps that are typically taken within a formal consultation as a guide to a process for assessing and evaluating change. For instance steps would have included an assessment of the status quo in order to establish a baseline, an explicit case made for making a change, and an evaluation of the impact of change in order to demonstrate whether there has been a service improvement and any further adjustments in order to achieve continuous improvement. The lack of an evaluation or audit of the community hospital inpatient service and community home based service before the change has made comparisons problematic.

There is a lack of clarity regarding the way that public opinion, including patient experience, may influence the decision about the future reconfiguration. It is suggested that the inpatient beds are not for negotiation. It is also recorded that should the service be shown to be unsafe, unsustainable or not of quality, then the pilot would conclude and the inpatient service would be reinstated. The question is whether this is being considered for the population as a whole, or for the cohort of frail older people who would typically use the inpatient beds.

The evaluation focused on the impact on the whole system, rather than on the cohort of patients, although recognised that the numbers were too small, the timescale too short, and the numbers of variables too high to be able to be definitive about cause and effect on the system overall from closing the beds. There is more that could have been done to assess the impact on the cohort of patients affected by the change, although the work on case note review is acknowledged.

The limited staff voice in the evaluation is an omission. It would have been helpful to know about staff recruitment, retention, sickness levels and job satisfaction, as well as their views on delivering care to people at home who would otherwise have been an inpatient in Torrington community hospital. My remit is to review the evaluation for the test of change ending March 2014. However, the enhanced community-based service continues beyond the end of the test of change, and it would be expected that the staffing levels and standards continue to be managed and monitored to determine sustainability and appropriateness.

The CCG and NDHT have demonstrated a willingness to be flexible, share information, present a balanced picture, and hold many interviews and meetings with local people. There is a recognition that the lack of notice of the announcement of the closure of the beds resulted in a lack of trust, and subsequent events have not improved on this position.

There was recognition by the CCG of the sensitivity of closing local community hospital beds, and a commitment to incorporate an independent evaluation of the impact of the change at the start of the process by working with a recognised academic or healthcare institution. Had this step been taken at the design stage of the process, it may have given the Torrington test of change more legitimacy.

Lessons

These points have been discussed with the officers concerned and summarise some of the considerations with the benefit of hindsight.

- Earlier engagement with local people so that the service design and evaluation is co-produced
- Greater attention to the steps in making service changes, and in particular a full audit of the community hospital and community service before the change in order to enable a comparison to be made
- Greater clarity in what the NHS is asking local people to express their views on, and how this might impact on the design of the service
- An external evaluation of the service model given the sensitivity and importance of testing the closing of community hospital beds
- Consideration to the particular cohort of patients to be affected and case management by the complex care team to consider the clinical and social implications of the change, attend to these and report them accordingly.
- Closer working with the GPs on the impact of residents of Torrington
- More opportunity for formally capturing the views and experiences of staff working in the new model of service

Recommendations

The draft Evaluation Report and Draft Engagement Report form the basis for decision-making, and it is therefore important that they capture the work that has been done and make it clear how recommendations for decision-makers have been formed.

- **Redraft of the Evaluation Report**

This would be to reflect more fully the work that has been done, cross reference to supporting papers and reflect any service improvements planned as a result of the evaluation of the test of change.

- **Redraft of the Engagement Report**

This would be to present a more comprehensive account of engagement, capture views and contributions more systematically, update for more recent evidence, and demonstrate more fully how contributions have been influencing not only the process of engagement but also the service.

12. Conclusions

This review of the evaluation assesses whether the design, method and conclusions of the study were appropriate and whether the evaluation was sufficiently accurate, robust, balanced and objective.

My assessment of the evaluation was that there was a logical design, with a process for measuring data against NHS outcomes framework.   I agree with the limitations already identified by the CCG and Trust cited in the Engagement Report regarding the design, method and delivery of the evaluation and in particular the lack of a clear baseline in order to provide a full understanding and presentation of the service being replaced. There are issues about the focus being high level, system-wide and less on the cohort of affected patients. Although the method can be viewed as systematic, the way that the evidence supports the conclusions reached is not so clear. The overall conclusion that the new model does not have a negative impact on the whole system and for the wider community would appear to be a reasonable assumption. The question not directly addressed is whether the cohort of patients are adversely affected and how this is being managed. The evaluation report is clear in lessons learned, and in particular that the evaluation should have been designed more collaboratively and earlier in the process.

In assessing whether the evaluation data analysis is accurate and robust, I can confirm that the data sources, analysis and validation are systematic. However the data could have presented in a clearer way within the evaluation report. There is a clear recognition that the short timescale for the change and the low numbers affected means that it is not possible to be confident about cause and effect or trends. However the CCG and NDHT wanted to be assured that there were no significant negative effects on the whole health and care system in terms of an increase in use of other services by the population and this was demonstrated. Clearly the impact on the cohort of patients also needs to be taken into account.

In assessing whether the evaluation is objective and balanced, I understand that the conclusions reached from the measures in the evaluation framework have been made collaboratively, and that ongoing input from the oversight group and others has contributed to this. Those promoting the model, based on national policy, research evidence and good practice, are understandably hoping that the model is appropriate for Torrington in the way that I understand they are exploring for Moretonhampstead and Budleigh Salterton.

A key aspect of this evaluation is how to capture the views and experiences of patients, carers, the community overall, staff, GPs, health bodies, social services etc.   The report on engagement demonstrates the enormous amount of work carried out to try to inform, engage and seek contributions from those concerned. If the conclusions of the evaluation are to be robust, they need to be able to reflect the patient experience, staff perceptions and views, and those concerned with referring, delivering and receiving care. It may be argued that the engagement has been substantial, and also flexible and adapting. Within the engagement report, deficiencies in the process are identified and lessons learnt. It is clear from the feedback, patient stories on the website, votes in the poll, views expressed in public meetings and others that the closure of the beds and investment in the community and hospital as a hub has not attracted wide support. Local people, and in particular STITCH continue to express their lack of confidence in the model and the process. I agree with the Healthwatch assessment that it is unclear which services were subject to negotiation with the community.

The analysis of the whole system service activity and the financial assessment would appear to support the continuation of the model of care. However it has been shown that many patients, carers and the community have yet to be convinced that it is a better service that the previous configuration of having a community hospital with beds within Torrington.

There is scope to improve the next version of the CCG/NDHT evaluation report so that it is more comprehensive, clearer and more focused, with appropriate cross referencing to supporting documents and sufficient attention given to the considerable amount of work that has been carried out on this proposed service change both by the statutory organisations and the local people of Torrington.

I understand that the local MP, Geoffrey Cox MP QC, has offered to chair a public meeting be held following this review of the evaluation, and this is to be welcomed. He suggests that there is a need to signal a change in the way of working. He also recommended that any recommendation on the model be deferred until this review has been submitted and the evaluation and engagement reports are completed.

The evaluation of the Torrington model in the test of change has been undertaken with a view to considering developing this model over a wider area across Devon. Therefore this has implications beyond the residents of Torrington and its surrounding parishes.

Appendix A Selection of References

NB: Not all documents have a reference, author, date or indication of status

No.	Evaluation and Engagement Reports Sent by CCG
	Main Evaluation Report
1	Appendix 5 Review of the Torrington Test of Change Work Book Version 11 Northern Devon Healthcare NHS Trust
	Main Engagement Report for the Evaluation
2	Torrington Community Cares: Meeting local needs Public, staff and stakeholder engagement and involvement report Version 3.0 Northern Devon Healthcare NHS Trust and Northern, Eastern and Western Devon Clinical Commissioning Group

NB: I have been directed by the CCG to these two documents as being the evaluation reports to be reviewed

No	Reports for Decision-making
	Joint Board
3	Joint Board Paper - Presentation of final reports of the model of home-based care and engagement and involvement activities during the Torrington Community Cares Test of Change Northern Devon Healthcare NHS Trust
	Health and Wellbeing
4	6 Month Evaluation Report A Summary for the Health and Wellbeing Scrutiny Committee 16th June 2014 Northern Devon Healthcare NHS Trust

NB: These reports I understand to be those presenting recommendations for decision-making based on the two evaluation reports

No.	Supporting Papers Reports by CCG
5	Torrington Community Cares Oversight Group Terms of Reference NEW Devon CCG
6	Torrington Community Cares Engagement and Involvement Final Report Summary Northern Devon Healthcare NHS Trust and Northern, Eastern and Western Devon Clinical Commissioning Group
7	Appendix 1 Meeting Local Need Evaluation Framework NEW Devon CCG
8	Appendix 4a - Draft Service Change Readiness Framework
9	Appendix 5 Review of the Torrington Test of Change Work Book Version 11 Northern Devon Healthcare NHS Trust
10	Appendix 7 Care Closer to Home Rapid Evidence Review Devon County Council Public Health Devon
11	Appendix 8 Equality Impact Assessment : Test of Change for Torrington and Parishes Community Services Northern Devon Healthcare NHS Trust

	Papers Supporting Engagement sent by CCG
12	Appendix 1 Torrington – meeting local needs
13	Appendix 2 GP position statement letter and response
14	Appendix 3 Oversight group terms of reference
15	Appendix 4 Focused workshop series report
16	Appendix 5 Patient story report
17	Appendix 6 Patient experience survey report
18	Appendix 7 Freedom of Information
19	Appendix 8 Rotary Club meeting report
20	Appendix 9 Full list of media coverage
21	Appendix 10 Healthwatch Torrington 200 report recommendations and response
22	Appendix 11.i – 11.v Publications
23	Appendix 11.i Drop-in flyer
24	Appendix 11.ii Focused workshop series poster
25	Appendix 11.iii North Devon Journal advert
26	Appendix 11.iv Torrington clinic timetable
27	Appendix 11.v Tour and Talk flyer

No.	**Selection of Documents from Torrington Community Cares Website**
28	Torrington 8 week evaluation
29	Review of the Torrington Pilot 1st October 2013 to 26th November 2013 NEW Devon CCG
30	Review of the Torrington Test of Change version 8
31	Meeting Local Needs – Involving you in shaping future healthcare in the Torrington Area Torrington Community Cares
32	Health Needs of the Population
33	The national context of care closer to home
34	The Effectiveness of home based care
35	What home based care is available
36	Patient Case Studies – narrative and videos
37	New Ways of Working in Northern and Eastern Devon
38	How should we provide better care as the population ages
39	Nursing the Nation – video
40	Freedom of Information Requests and Responses
41	Letter from NDHT CEO to Torridge District Council July 2014
42	Final Report on Engagement (which also included the 6 month evaluation) submitted to Health and Wellbeing Scrutiny Committee June 2014

Appendix B Services in Torrington Community Hospital

The list of current, new and planned services is taken from the Torrington Community Cares Website. The list has been extended and commented on, following on from comments received and the final list will need to be validated. However this does illustrate the range of services offered, those planned or re-located to the hospital, perceived gaps and potential developments.

Existing and Current Services

Service	Comment
Orthoptist	
Heart Failure	
Breast clinic	
Rheumatology	
Gynaecology	
Muskulo-skeletal physiotherapy	
Paediatric physiotherapy	
Falls Group	
Chiropody	
Continence	
Occupational Therapy	
Family Planning	Understand sessions reduced to one a week because of current lack of take up

New or Re-Located Services

Service	Comment
Ultrasound	Understand that the hospital previously had a bladder scanner. This extends the service further.
Ante natal and Post-natal clinics	Moved from the Health Centre and is a new provision for the hospital
IV Day treatments	Previously offered to inpatients and day patients on the ward, and now offered as specific day sessions with an extended range of treatments.

Coming Soon

Service	Comment
Voluntary advice	Discussions ongoing with Torrage
Leg Club	Identified by local people as a need in the focused workshops
Medicines for older people	

Service Gap

Service	Comment
Clinics for Older People	STITCH has commented that, given the beds

	catered for older people with complex care needs, there is an argument for providing clinics for Care of the Elderly in order to supplement local provision and meet local need.
ENT	It is understood that the ENT clinic was in place prior to the TOC and now not currently offered.

Services Closed or Relocated (Temporarily)

Service	Comment
10 inpatient beds (offering 24/7 nursing care)	Community hospital beds offered in other community hospitals
Out-of-Hours	Understand now currently based in Barnstaple (8am-8pm)

Appendix C Tasks Undertaken for the Commission

Task	Date
Confirm commission	1st August
Read and analyse documentation to date	5th August
Visit hospital for tour and talk - Kerry Burton and Nicki Kennelly Work with Data analyst - Nic Harrison	6th August
Interview: Dr Stephen Miller Attendance at Torrington Meeting (CCG and NDHT) Interview: Emma Interview: David McClellan Meeting with STITCH	7th August
Further analysis and recording	11th August
Follow up telephone calls to key individuals including: Kerry Burton, Nic Harrison, Dr Moggy, Dr Tim Dudgeon	12th /13th August
Draft Report	14th August
Receive additional material	16th August
Telephone call: Steve Hudson	18th Aug
Review draft report in the light of additional evidence	20th August
Conference Calls – KB (CCG) and NH (NDHT)	End of August
Submit Draft Report of the Review	8th September
Receive comments on accuracy from STITCH, CCG & NDHT and amend accordingly	16th September
Finalise Report	17th September

Appendix D   Review of Key Evidence on Community Hospital Services

I have reviewed some key evidence on the role of community hospitals, drawing on a selection of papers providing evidence from randomised controlled trials or studies that have been published in peer review journals.

A key role of community hospitals is the provision of a rehabilitation service. Patients benefiting from this local service are often older people who require a period of intensive rehabilitation after a fall or an acute intervention, and before being able to return home.

A series of randomised controlled studies in Leeds Bradford have shown that older people benefit from rehabilitation in their local community hospital. One study involved 220 patients who had care either in a DGH or a community hospital. The results of the dependency scores and functionality showed improved results for those patients in the community hospitals. The study concluded that care in the community hospital was consistent with greater independence (Green et al 2005). A similar study in Norway involving 142 patients concluded that intermediate care was highly effective in community hospitals, and recorded a lower mortality rate, higher levels of independence and fewer re-admissions in those patients in the community hospital (Garasen 2007).

A further study of 490 patients demonstrated that rehabilitation was cost effective for post-acute rehabilitation in community hospitals (O'Reilly et al 2008).

Interviews with patients demonstrated a high level of satisfaction, and that the community hospital service was welcomed by patients (Small et al 2007).

A study of the presence and nature of integrated care in community hospitals assessed 48 community hospital services in England, and found evidence of a multiple types of integration for all services. Those most frequently provided in partnerships were palliative care and intermediate care. The types of integration most prevalent in community hospitals were multidisciplinary working and joint working with secondary care and primary care. There were examples of multi-agency working in many services (Tucker 2013).

Community hospitals are a key part of the community health model. A growing number of commissioners and providers are reviewing their community hospital offering to ensure they are meeting the changing needs of their local population. The trend is a move away from inpatient care, with greater focus on rehabilitation, day care and outpatient services (NHS Confederation 2013).

There is a view that the strengths of community hospitals may be in linking primary and secondary care and providing a location for the delivery of complex packages of health and social care and public health (Heaney *et al.* 2006).

References

Garasen et al. (2007)   *"Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: a randomised controlled trial."* BMC Public Health 7:68

Green et al. (2005) *"Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial."* Br Med J 331(7512):317-322.

Heaney et al. (2006) *"Community hospitals--the place of local service provision in a modernising NHS"* University of Aberdeen Centre for Rural Health

O'Reilly et al (2008) *"Post-acute care for older people in community hospitals--a cost-effectiveness analysis within a multi-centre randomised controlled trial."* Age and Ageing 37(5):513-520.

Small et al. (2007) *"The patient experience of community hospital - the process of care as a determinant of satisfaction."* Journal of Evaluation in Clinical Practice: 95-101

Tucker, H. (2006) *"Integrating Care in Community Hospitals."* Journal of Integrated Care 14(6) December 2006 :3-10.

Tucker, H., Moore, B., Jones, S., Marriott, J. (2008) *"Profiling Community Hospitals in England 1998- 2008"* Community Hospitals Association: Department of Health and Community Health Partnership.

Tucker (2013) *"Discovering integrated care in community hospitals"* Journal of Integrated Care 21;6 336-346

NHS Confederation (2013) *"Transforming local care – community healthcare rise to the challenge."* Briefing Paper

Appendix E STITCH Submission Report

I have summarised the recommendations and key points in the STITCH Report on the 6 Month Evaluation and from the 39 Appendices. I have summarised the material for ease of reference in my review. This paper accompanies the summary of key themes from patient stories submitted by STITCH in Appendix E.

I have reflected the content of the STITCH report and appendices as they stand. I understand that the NEW Devon CCG and NDHT are responding to the report and will be offering some clarifications and corrections on some of the points made by STITCH.

STITCH evidence is in shaded text.

Key Points and Recommendation from STITCH in their Report on the 6 Month Evaluation and Supporting 39 Appendices

STITCH has made the case that there has not been proper engagement, that the process has been flawed, that there was no evaluation before the change to enable a comparison to be made, and that the evaluation fails the four tests of change for the NHS. Overall STITCH has not been convinced that the case has been made to show that the standard of care under the care closer to home model is as good as or better than when hospital care was in place.

STITCH recommends that the Oversight Group, CCG and NDHT:

- **Rejects the "care closer to home" model of healthcare**
- **That a halt be called to the flawed process**
- **That the hospital beds re-open**
- **That talks are set up with the community and for the community to create a tailor-made model of healthcare for our town and surrounding parishes.**

1. Public Meeting Rejected Evaluation

Over 200 people at a public meeting on 9th August rejected the evaluation report and its recommendations on the basis of bias as it was a self-evaluation with no validity.

2. Oversight Group Could Not Support Outcome of Evaluation

The evaluation report was incomplete and not provided to members with sufficient time to consider it.

3. No confidence in the Oversight Group

Issues of terms of reference, membership, attendance, lack of an independent chair and secretary, CCG switching location of the meetings at short notice, and a view that the meetings were dominated by the CCG and NDHT.

4. Local NHS not engaging on the model or the issue of the inpatient beds

The question being asked is what services would the residents of Torrington benefit from being able to access in TCH rather than NDDH. Many local people want to express their views on the beds and the value of the inpatient provision providing a 24/7 service rather than only having a home-based 8-8 provision, but this was not the question being asked of local people.

5. Impact of Closure of Beds in NDDH – Code Red Days

Concern about the pressure on the NDDH, and in particular times when the hospital is code red as inpatient beds are full. Previously could have had patients step down to TCH. The impact assessment needed to look at the wider impact on health and social care.

6. Dispute on Definition of "New" services in TCH

Local NHS describing new services now being offered in the hospital, although almost all had been offered before.

7. Staffing Numbers in Community not Enhanced sufficiently

FOI request showed only 2 qualified nurses on the team and STITCH has a view that the service is understaffed and under-resourced for the geographical area served. There is an issue with staff sickness and absence rates currently.

8. Concerns for Overnight Care

A statement that out-of-hours services are not included but in practice the service has reduced for some patients from 24/7 to 8-8, and access to care and support at night needs to be considered. A spokesperson for the local NHS has said that overnight care is not satisfactory.

9. Local NHS Reports and Documents not Adequate

The Engagement report which is described as "lacking objectivity, accurate representation and is unprofessional." The report has no author recorded. The CCG communications team only interviewed 3 patients to get patient views according to the Oversight group minutes, although this number is not recorded in the document. There is a lack of clarity about how many patients were interviewed and how impartial the interviews were. The promise to include the Parish Poll outcome in the Engagement Report has not been kept.

10. Published Evidence Bias

The paper on care closer to home looked at evidence only of home care. This "served to strengthen the opinion that we were being talked at and not listened to." STITCH has made the point that, in spite of a commitment, there was no external, impartial, evaluator on the oversight group from the start to the end of the process to oversee and administer the evaluation. There is also a concern that only the trust evidence was included in their report and this omitted evidence such as the referendum result, town council's views, Devon Senior Voice survey, Healthwatch survey etc.

11. No Assessment Before the Change – Evaluation or Equality Impact Assessment

An EIA developed recently although some concerns that it is not fully developed. There is concern that there was no evaluation was undertaken before the change to allow a comparison to be made. Equally there was no impact assessment done prior, so there was no base line established for comparison.

12. Need Support from GP Commissioners (1st Test of Change NHS)

Letters from current and retired GPs alert to concerns about the service and do not provide wholehearted support for the model of service

13. Need Clarity on Evidence Base (2nd Test of Change NHS)

One of the key messages from the report on the evidence for home care is the importance of patient selection. STITCH has raised questions on the process for patient selection and makes the case that patients have been put at risk during the trial (see patient stories submission). This raises the question of what happens to those patients for whom home care is not appropriate.

14. Need to strengthen patient engagement (3rd Test of Change NHS)

The local NHS is closed to the idea of beds in TCH. "The Trust and CCG omitted to evaluate the popular ad well-regarded healthcare model prior to the "care closer to home" model so we are unable to compare the service before and after the reconfiguration."

15. Needs to be consistent with current and prospective patient choice (4th Test of Change NHS)

The choice has been taken away from the community with no consultation and there has been no proper research into the need for beds. A breach of the statement "no decision about me without me." There is a concern about the safety of patients during the test of change, and the experiences and views of 17 patients and carers are provided in supporting evidence from STITCH.

Source: STITCH Submission to CCG/NDHT August 2014

Appendix F STITCH Submission Patient Stories

As an independent reviewer of the evaluation and supporting material, I have analysed the submissions from patients and carers provided by STITCH in order to enable me to reflect the main messages in the stories for my report. I trust I have adequately reflected the concerns and issues identified by those concerned in this summary paper. I have used the numbering system used by STITCH as the patient identifier. I understand that NDHT are considering this evidence and investigating where appropriate. The content below has been submitted by STITCH.

STITCH evidence is in shaded text.

STITCH Submission

Analysis of 17 Patient Stories Submitted as part of evidence from STITCH Submitted on 18th August 2014

Submissions and Complaints

17 patient accounts have been submitted, of which 14 stories written by relatives or neighbours on behalf of patients, with the patients consent. The accounts describe elderly patients who have long-term conditions, are frail, and those who require palliative care and end of life care. Some of these patients require health care and interventions such as injections and physiotherapy. The accounts are in the nature of complaints and concerns which the CCG/Trust and STITCH asked local residents to identify. At least one of the accounts has been reported to PALs, although it is not clear if there has yet been a response. The CCG/Trust has undertaken to follow up complaints.

Three main themes have emerged:

1. Difficulties in getting a bed in TCH
2. Problems with the Lack of Access to Beds in TCH
3. Difficulties with Enhanced Community Care

1. Difficulty in getting a bed in TCH

12 of the patient experiences cite difficulties in getting a bed in TCH both during the time that the beds were fully open, and also when there were 6 beds open for the 8 weeks in the test of change.

- Reasons given in the accounts were understood to be that there was a waiting list for the beds and no empty beds, although this was challenged and disproved (10).
- Another was that there was no physiotherapy, although this was challenged (13 & 14).

- After a long stay in DGH a patient was offered a bed in Holsworthy CH, and had to press for TCH (4).
- One wife said that she had to fight for a palliative care bed for her husband saying that it was a good service and it was easy for her to visit which was an important consideration as she did not drive (5)
- There were difficulties getting a bed during the 8 week test of change, as there was confusion about whether these beds that had been re-opened could be used or not (6)

"Let there be no illusions about why we have less and less admissions to TCH"(7)

2. Problems with the Lack of Access to Beds in TCH

The implications of not getting a bed in the hospital were recounted in the patient stories, such as relatives having difficulty visiting, and losing the benefit of adequate discharge arrangements to home being made locally by the hospital staff as opposed to being arranged by the DGH.

- One relative described the daily drive of 30 miles to South Molton, and said on the bus this would have required two buses and a 15 minute walk (11)
- A wife described her husband's previous experiences in TCH for rehabilitation, but that when he had his final illness he had to be in Holsworthy, which was far for her to visit (15).
- One account was of inadequate discharge arrangements from NDDH to home, an eventual readmission and then inadequate discharge arrangements requiring neighbours to help out as an emergency whilst community care put in place (1).
- One relative said that if the beds had been in place, the patient's discharge arrangements could have been attended to properly (9).
- One carer said that the inpatient provision at TCH was a good service and it was easy to visit.
- One carer described the patient's positive experience of rehabilitation in TCH, but said that there was pressure on beds and when she was at the end of life she had to go to a nursing home to die. This experience was used to show that there was a need for the beds and the service (3).

"The lack of beds in Torrington does not affect just potential patients but also has a knock on effect on the relatives both emotionally and financially." (15)

3. Difficulties with Enhanced Community Care

Informal carers of patients in the community, such as relatives and neighbours, describe situations when the community health care has been unreliable or has not been adequate in their view. This service is contrasted with the 24/7 care provided in beds in TCH.

- There are accounts of staff providing home-based care being unreliable and inexperienced (2).
- A relative has said that regarding home care there was insufficient information and contact details, and relatives do not feel properly supported. The relative also added that if the beds were in place, the care could be given properly (9).
- The care is poor and the visits are inadequate (8).

- We have experienced difficulties with a lack of equipment in the community, lack of availability of staff, and lack of support (7).

"People coming and going, writing notes, but no personal care given. I can't give care alone with no help. This community nursing care isn't working. Its unsafe for patients" (12)

Other Concerns

One patient has expressed concern about the service that will be provided at TCH in the future, requesting clarification over the procurement of podiatry services (17). One patient has queried the use of the video and authorisation of material (16).

Commentary
I have summarised the recommendations and key points in the STITCH Report on the 6 Month Evaluation and from the 39 Appendices. I have summarised the material for ease of reference in my review. This paper accompanies the summary of key themes from patient stories submitted by STITCH in Appendix E.

I have reflected the content of the STITCH report and appendices as they stand. I understand that the NEW Devon CCG and NDHT are responding to the report and will be offering some clarifications and corrections on some of the points made by STITCH.

I understand that further investigation into these patient experiences and perceptions will be undertaken by the CCG/Trust.

The timing of these experiences will need to be taken into account. For instance, some of the issues for concerns regarding community care may have occurred as the service was being established, although a number have been cited as occurring after the test of change when improved working practices and processes should have been in place.

Patients and their carers have recounted their confidence in the inpatient provision at TCH. They have also described their difficulties in accessing the service over the past few years which they have used to demonstrate need. They also raise concerns that there may have been other factors adversely affecting the optimum utilisation of the hospital, such as preparing for change.

The cohort of patients described would appear to reflect the cohort of patients who would have otherwise gone into TCH in the past, although this will need to be validated.

Source: STITCH Submission to CCG/NDHT August 2014