Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

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Dear Michael

Many thanks for your letter and please accept my sincere apologies for the delay in replying. My team were preoccupied with the engagement events which has meant all responses to correspondence have taken longer than I would have liked.

I read your letter with interest and I appreciate the efforts to which you have gone to understand the business model and strategy of your local healthcare trust.

To respond to your general theme, every NHS organisation develops strategies to set a course for the future which respond to the national context and the local commissioning intentions.

In this, we are no different. The strategy to which you refer "Our Ambitions 2008-2013" was our response to the national review High Quality Care for All Next Stage Review, 2008 and the commissioner's intentions outlined in NHS Devon's *The Way Ahead - Five Years of Improvement 2008 – 2013* (Devon Primary Care Trust and Devon County Council 2008) and 'Optimising Community Services'. We also refer frequently to Devon County Council's 2011 Market Position Statement and Demand Analysis.

At the time these documents were drafted, the prevailing clinical and financial context was very different. We were two years away from the NHS spending review and impact of the current recession on our funding. We were also three years away from the Francis review into the care at Mid Staffordshire and the NHS reorganisation prompted by the Health and Social Care Act 2012.

The impact of these events is – rightly - having serious and far-reaching consequences on the way the NHS runs its clinical services. The pace of change means that historic standards that were considered acceptable are no longer deemed thus and health economies are moving quickly to create financially sustainable clinical services in this context of 'flat-cash' funding.

Since 2008, we have embarked on an NHS Foundation Trust application. This application was stalled in 2011 by the transfer of the eastern community services to our management, however it is underway again now. This application has required the development of very detailed business plans, clinical plans, estates, governance and financial strategies which have superceded any previous strategies.

As part of the consultation to become a Foundation Trust we visited many community groups and held several public meetings to gather views on our vision and aspirations. On 9 November 2011 we came to Torrington to brief the community on our new vision and strategy which is: "We will deliver local integrated health and social care to support people to live as healthily as possible, recognising the differing needs of our local communities across Devon."

The meeting was well attended and we valued the feedback we received.

The Trust's website contains a graphical representation of how this strategy will be achieved and what it aims to deliver: http://www.northdevonhealth.nhs.uk/about/strategy/. You will notice that under re-shaping community hospitals it refers to 'fewer beds'. We have been very open about this statement.

The documentation to support this strategy is contained within our Foundation Trust application and replaces the 2008-13 strategy, Our Ambitions.

Equity of access and bringing care closer to home is the guiding principle of this strategy, and is aligned to the NEW Devon Clinical Commissioning Group's strategy of 'Care Closer to Home', which is currently out for consultation: http://www.newdevonccg.nhs.uk/northern/get-involved/care-closer-to-home--have-your-say/100522

I hope this overview has provided you with sufficient information to allow me to counter your claim that our approach in Torrington is outside any existing strategy. It is absolutely our long-term strategy to care for as many people as we can in their own homes. It is also the sign of a strong and responsive organisation that we are able to adapt our business to the prevailing political, clinical and financial contexts.

Home-based care is a highly efficient and effective model of care and we are very confident that the pilot in Torrington will be successful. As you know, any permanent service change will be fully tested during a consultation period, and we hope you have the reassurance of our commitment to a full engagement exercise.

To cover the remainder of your points, I would like to go through each in turn to ensure we provide a sufficiently thorough response.

In favour of keeping patients within the acute hospitals of Barnstaple, Exeter and Plymouth for longer so they may be discharged directly home.

There is no clinical case for keeping people in an acute hospital bed for any longer than needed. To do so would significantly impact on the outcomes for that patient: the longer patients aged over 85yrs spend in any institution the more dependent they become and are less able to live independently.

There is a place for community beds. These not only release an acute bed but return a patient to his/her community where relatives and friends can visit them

We do not disagree that there is a medical need for some community beds. However, a small community hospital like Torrington is naturally limited in the clinical services it can provide, particularly without the consultant cover that exists in the larger units in Bideford and South Molton.

The evaluation of the test of change will uncover the case for and against inpatient beds at Torrington according to a range of criteria grouped around performance, clinical effectiveness, patient experience and value for money.

Our hypothesis is that the patients currently utilising the beds at Torrington Community Hospital can be supported by our community teams, who can actually offer more services and more intervention in the patient's own home.

Given that the patient is in their own home, visits from relatives and friends will be just as easy with the added advantage of being within the privacy of their own home.

Studies have shown that the further a patient lives from an NHS service, the less likely or the later they are to use it.

This fact is very well known by the planners of rural healthcare provision, and Devon's Public Health team also correlate deprivation indices with the reluctance to access services.

The duty of care and the obligation to provide NHS care free at the point of need or delivery is a guiding principle for the NHS that is subconsciously engrained in our approach.

Centralisation of care tends to occur in waves as healthcare advances are implemented in the NHS. At one point you could only get an x-ray in Exeter, the same for MRI scans. In the past only doctors could prescribe medication. As the technology becomes more readily available, its use disperses further into communities. We now operate an NHS service with local MRI, X-ray in community hospitals and community nurses who can prescribe medication in your own home.

Our response to the issues of deprivation and rurality is to bring care to people's homes. To do this requires the debate to move away from physical buildings – as symbols of NHS care – and for people to have more awareness about the clinical services they need to remain living healthily in their own communities.

We are not surprised that this vision causes very real tensions between members of the community for whom buildings are very important. We do not underestimate the challenge ahead but feel we are on very sure clinical footing to continue testing the model.

Refurbish Torrington Community Hospital. Develop community hospitals to expand local provision and improve access to services.

This line is one you quote from the Estates Strategy written in 2009/10. At the time of writing we were indeed exploring ways to solve our intractable issues with the Community Hospital building, which remains not fit for the purpose. One of the proposals was to partner with an independent service provider.

This scheme failed on two counts – the withdrawal of capital funding available to Trusts due to the recession and the clinical governance restrictions of an NHS inpatient service provided by another provider.

It is possible that, with the opening up of the healthcare market following the 2012 Health and Social Care Act, the same restrictions would not be such as barrier today. This may be something the commissioners would wish to consider in future.

The financial and rigorous clinical climate means that Trusts and commissioners must examine every penny that is spent on behalf of the local community. This money has to be used for services which are sustainable, value for money and get the best outcomes for patients.

I would vigorously refute your claim that we have lost our way. We have not abandoned a strategy, but built upon our success and changed course according to the prevailing winds. I cannot see anything in our plans to provide care for patients in their own homes which goes counter for the expectation of 'no decision without me'.

We have an extremely experienced Board at the Northern Devon Healthcare Trust who have steered local services through several reorganisations, financial and clinical challenges, changes of policy and recessions.

I feel duty-bound to point out that we are also a highly performing Trust. We do focus on what matters to patients: waiting times, infection control, cancer care as well as focusing on service developments which improve outcomes for patients.

It is clear from your letter that we are failing to get past the issue of what the community feels it is losing: beds, onto what the community will gain: additional services, a stronger community team and greater influence over the services offered in the town. I hope that the consultation period provides the forum to allow us to move this debate on.

Through the many meetings we are having with the local community it is becoming clear that the beds have more symbolic value than what is actually clinically required. We are listening keenly to feedback from local residents, and going out to the furthest villages of Greater Torrington to ensure that it is not just those that are within walking distance to the Hospital whose views are captured.

I am pleased you feel able to write to me directly and so frankly, and appreciate the time you have taken to point out these challenges.

I am aware you have expressed an interest in similar schemes currently operating across Devon so as well as extending an invite to the Council to talk directly to the community staff in Torrington, I also offer to accommodate a visit to the Hospital at Home scheme in Exmouth.

I am very keen for you and your fellow councillors to be fully informed and engaged in this process and hope that you continue to ensure that the community knows how to raise concerns and ask questions.

To this end, I would like to request that the Greater Torrington Town Council nominates a member to attend the Torrington Community Cares Oversight Group meetings. The purpose of this group is to ensure that the views of as many local people as possible are captured to inform the test of change and brings influence to the future uses of the hospital building. Membership will be broad, with town, parish, district and county representatives sitting alongside senior NHS staff, GPs, voluntary agencies and social services. The councillor that you nominate will be asked to ensure that they regularly update the remaining members of the Council as to progress and news.

I look forward to hearing from you.

Yours faithfully

Roger French
Chair