PH/15/9
Health and Wellbeing Scrutiny Committee
24 March 2015

Torrington 'Test of Change'

Report of the Member Investigation

Background

In July 2013, the North, East & West Devon Clinical Commissioning Group (CCG) launched a 6 month pilot program of 'at home' care in Torrington (1st September 2013 – 28th February 2014). The goal was to target health services in order to keep patients at home rather than in a hospital bed, and to this end it was announced that the 10 beds at the Torrington Community Hospital would be closed for the duration of the pilot.

There was no consultation prior to the announcement (either public or otherwise), and there was an immediate public reaction against the proposals. This resulted in the CCG reluctantly 'agreeing' to re-open 6 of the beds for an 8 week period as a 'safety-net' for the public in Torrington. There were also various consultations hastily convened in August and September, and the pilot officially began on 1st October (the 10 beds were closed 1st September, with 6 beds re-opened 1st October).

Throughout the test of change there has been strong and persistent resistance to the changes within the community. A local action group 'Save the Irreplaceable Torrington Community Hospital' (STITCH) was formed, and a public referendum was held, with a 32.6% turnout (in just 5 hours!), and over 99% voting against the bed closures!

A number of concerns have been raised, by both professionals and the public, with few being answered adequately. Health Watch conducted a survey (Torrington 200) in the town centre, and provided a report on their findings. There were 161 eligible respondents, over 75% of them were aware of the project – almost all of whom had only heard about it by 'word-of-mouth'. Over half understood it to be about closing beds, and a fifth thought it was about closing the hospital. 38 respondents (24%) had experienced enhanced home-based care, 5 were partly positive, but all raised concerns. Two thirds expressed their desire to remain independent for as long as possible, but stated that they would rather go to hospital than rely on home-based care. Three quarters wished to see inpatient beds retained.

STITCH have consistently challenged the claims and assertions of the CCG regarding the national data used as the initial justification for the bed closures, the lack of consultation, the failure to assess the service provision prior to the test of change, the increased morbidity rate (with claims of a 40% increase since the start of the pilot), and the lack of local GP support for the pilot. Despite the efforts of the CCG to answer these concerns, almost all of them are still lobbied as they were originally, clearly showing that STITCH have not received satisfactory answers.

As stated above, there has been no public or official support from either of the two GP practices in Torrington. In contrast, one local GP wrote a letter of objection at the start of the process, and two local GPs marched with the public and spoke against the pilot when STITCH presented a petition to the hospital, the CCG have acknowledged the lack of local GP support, but have focused on the support of the project expressed by non-local GPs.

Prior to the concept of the Torrington test of change, Devon's Health & Wellbeing Scrutiny Committee, through their 'Future of Community Hospitals Task Group' report (September 2012) recognised that there is a need to develop patient services without the restrictions of a hospital building, but understood the importance of community involvement, and clearly recommended that:

"Before any changes are made there needs to be real, meaningful and early engagement over the future of services, so that local people are shaping the future direction of local healthcare" (Recommendation 10)

The Current Situation

Despite the overwhelming objections to the closing of the hospital beds, the lack of local GP support, the controversial and highly challenged results of the 'test of change' assessment, and the negative statement of the Oversight Group, the CCG have decided to 'ratify' the pilot as a success, and to replicate the process across Devon.

Responding to the concerns that it has often expressed, and to those of the public, and to the frustration of being 'unheard' by the CCG, the Great Torrington Town Council requested that DCC's Health & Wellbeing Scrutiny Committee refer the matter to the Secretary of State.

There are defined procedures surrounding this action, the first of which is for the Scrutiny Committee to investigate the issue, and satisfy itself that all avenues have been explored, and that the only recourse is to send it to the Secretary of State. In order to initiate this process, the Health & Wellbeing Scrutiny Committee set up a Task & Finish Group to look at the wide diversity of information, and develop a brief, clear report for consideration by the full Scrutiny Committee. The task group consists of Councillors Greenslade, Chugg, Yabsley and Dezart, and is chaired by Councillor Boyd.

Sources

A large number of documents have been studied in the development of this report, and a representative, although not exhaustive list includes:

- Resolutions and Reports of the Health & Wellbeing Scrutiny Committee
- Report of the Community Hospitals Task Group
- CCG Press Release (03/07/2013)
- Proposed Commissioning Intentions for the Northern Locality – Transforming Community Services (Care Closer to Home)
- The Proposal to remove inpatient beds and increase community services in Torrington – Equality impact assessment (Board Paper)
- Health Watch Devon – Torrington 200 Survey
- 6 month Evaluation Report – A Summary (Board Paper)
- Review of the Torrington Test of Change data at 8 weeks, 4 months and 6 months (Board Paper)
- Summary of 12 months Evaluation of Torrington Test of Change
- Meeting Local Needs – Evaluation Framework (Board Paper)
- Care Closer to Home Rapid Evidence Review (Board Paper)
- STITCH Report on the 6 month evaluation
- Health Watch Questionnaire Report
- Dr Tucker's Report to NEW Devon CCG – Torrington Community Cares Independent Review of Service Evaluation
- Tom Brooks' Commentary on Dr Tucker's Report
- Summary of the Views of NEW Devon CCG and NDHT to the comments from Dr Helen Tucker
- Response from NEW Devon CCG to the questions asked at the public meeting held on Saturday 8th November, chaired by Mr Geoffrey Cox in response to the Torrington developments

Validity of Data

The information published by the CCG has been over-whelming, confusing, ambiguous, and not all entirely relevant. Much of the statistical and financial information has been presented in different formats, and few if any are presented 'like-for-like'.

Mr Tom Brooks is a retired Management Consultant in healthcare effectiveness and efficiency (and who has advised NHS England and the Government), wrote a commentary on Dr Tuckers Report, highlighting that the evidence gathered *"…has been too narrow in scope and too general in nature…"* and that no 'control area' was used to validate the outcomes. He was also surprised that no effort was made to evaluate the effects of the 'efficiency measures' and other modifications that were introduced across Northern Devon at the same time as the pilot was being conducted.
Many of the improvements 'claimed' to be a result of the test of change will undoubtedly have been affected to a greater or lesser extent by the other changes made.

The Oversight Group that had been set-up by the CCG to monitor the robustness of the evidence gathered, agreed that the evidence was not definitive, and stated that it would prefer that inpatient beds were operated as part of the 'Care Closer to Home' service. However, at their board meeting of 26th November 2014, the CCG decided that the test of change at Torrington had been a success, and that they would enter into a program that would see the same measures extended across Devon.

There have been similar pilots' trialled across the country, with Cockermouth in Cumbria being the catalyst for many of the changes. Following the severe floods of 2007, it was agreed that a new, more modern service was required to ensure better access to, and more equal provision of health. Initially, a team of local GP's developed an "Asset Management" scheme that brought services much closer to people's homes, and utilised community buildings and voluntary groups. This enabled a more radical use of community hospitals as health 'hubs', which developed into inpatient bed closures, however, this was found to be an unsustainable step too far, and so inpatient beds have been restored.

Over the last three years in Budleigh Salterton, they have trialled/developed a "Hospital at Home" service. It has proven a great success, with a comfortable average of 14 patients (maximum of 21) being looked after by a team of medical professionals similar in number to the Community team at Torrington (which looks after around 200 patients).

Throughout the two year trial, consultations were held with the local population, resulting in the mutually agreed removal of inpatient beds, and the development of the hospital building into a 'health-hub'. There is a distinct advantage in the area as it is much more urbanised than Torrington, with good roads, a comprehensive public transport network, and an alternative hospital 10 minutes away.

In his commentary, Mr Brooks observes that *"During the time of the Torrington experiment, the NHS has been implementing 'efficiency measures'. These would have impacted pathways of care affecting NDHT and hence statistics on health episode activity in Northern Devon. There would also have been modifications due to revised advice from NICE, and many protocols and patient care pathways will have been reviewed by the provider (NDHT) in order to improve patient outcomes. All of these changes to healthcare practice, and others, even weather and influenza outbreaks will have impacted on the year by year comparisons, and some of them are likely to have had a greater impact on the Torrington experiment measurements than the changes arising from the new Torrington model."* He goes on to say that ***"It is unsafe to attribute the resultant statistics measured in Torrington as a reaction solely to the Torrington model."***

He further notes as "surprising" that whilst the Holsworthy and South Molton areas have continued to operate as Torrington did prior to the test of change, neither area has been used *"as a 'control area' for comparison with Torrington in evaluating outcomes and hence the evidence on quality and safety."*

Questions must be asked regarding the evidence that forms the basis of the report by the CCG, specifically questions of relevance:

- Attendances at A&E and at the MIUs will have had little or no relationship to the community hospital admissions in Torrington, which were predominantly 'step-down' from NDDH, or GP referrals.

- The prevalence or otherwise of 'out of hours' (OOH) telephone calls is also irrelevant to Torrington Hospital, as are the number of 999 calls, which could only impact on acute beds.
- The 'Family & Friends' test provided a score of +75…but only had a 16% response.
- A further survey was conducted, specific to the Torrington test of change, but the number of patients/responses is not mentioned, nor is the method of collection.

There have been many statements made by the CCG in determining their decision, some of which cause concern, including:

- Patients are more likely to fall whilst in hospital
- In Torrington, the length of time a professional spends travelling to see patients in their own homes is slightly less than when they just travelled to the hospital
- There will be plans put in place in case of inclement weather
- Although 64% expressed a wish to see the beds maintained…very few gave medical reasons for their opinion
- Local GPs remain concerned
- 97 people were saved from attending the acute hospital – this is incorrect, as the number is an hypothetical projection, directly affected by actively keeping people at home
- An £80k annual saving will be made, on emergency services, as a direct result of the Torrington model.

It is difficult to understand how such statements have given credence to the decision of the CCG to continue with the model. Many of them are no more then projections based on supposition. Others are completely contrary to the CCGs stance. Some bring more fundamental questions.

Assessing the Test of Change

From the outset, the CCG acknowledged the need for evidence-based data that would indicate whether or not the experiment was successful. The essential components for success were that it had to be a *"safe, sustainable and quality service (equal or better than before)".*

The evidence provided by the CCG, and corroborated by Dr Tuckers independent review, clearly shows a failure to achieve any of the above 'essential' criteria. This raises concerns in respect of the subsequent decision to claim it a success, and to expand the service changes across the county of Devon.

In order to look more closely at the validity, and success or otherwise of the test of change, it is necessary to consider the individual criteria of 'Safety', 'Sustainability', and 'Quality' in greater depth, considering the CCG view, followed by commentary based upon the views expressed by the public and the resultant questions, and then the comments of Dr Tucker in her Independent Review.

In respect of Safety

The CCG's View

The CCG acknowledge that they did not conduct a risk assessment prior to making the changes as it should have, and so in order to evaluate the safety aspect of those changes, it computed the following information:

1. Was there an increase in A&E attendances?
2. Was there an increase in emergency admissions to the acute hospital?
3. Was there an increase in attendances at the neighbouring MIUs?
4. Were more Torrington residents admitted to other community hospitals?
5. Was there an increase in out of hours (OOH) calls?
6. Was there an increase in 999 calls?
7. Was there an increased length of stay at NDDH?

8. Were Torrington patients more likely to be readmitted within 30 days?

The results of the 6 month trial provided the following answers:

1. No. But there was a 3% increase
2. No. There was a 10% decrease
3. No. There was a drop of 12%
4. No. There was a decrease of 56%
5. No. There was a decrease of 8%
6. Yes. There was an increase in Torrington in line with the Northern Locality as a whole
7. Yes. An average of +1.5 days
8. No. But there was a 3% increase

The CCG made the call as to the "Yes/No" decisions for each question, and whilst questions 1 and 8 indicated 3% increases statistically, conditions were added for the 12 month evaluation that enabled a claim of no actual change. The evaluation report concludes that there was no adverse impact on the local health system from the closure of the 10 community hospital beds and that, therefore, the changes to the service were safe.

Commentary
Torrington community hospital was used as both a "step-down" hospital (from the acute hospital), and a GP referral facility, as well as a centre for outpatient (specialising in physiotherapy), day care, and outreach services. The local MIU was moved to the GP surgeries some years ago. Because of this, there are a number of concerns regarding the relevance of the questions and answers:

1. A question that does not provide a valid, assessable answer. Anyone requiring emergency attention would have always gone directly to A&E. Therefore, any rise or fall in A&E attendances would have no impact on the community hospital.
2. A question that does not provide a valid, assessable answer. Emergency admissions to the acute hospital would have always occurred without any effect on community hospitals, unless the referral was for a community hospital inpatient.
3. A question that does not provide a valid, assessable answer. Attendances to MIUs bare no relationship with community hospital inpatients or admissions.
4. An expected result. The purpose of the pilot was to reduce the number of hospital admissions as a whole, and to keep/treat more patients at home. In order for this to work, there are, necessarily, fewer patients admitted to hospital beds. The reduction shown is a clear indicator that more patients were in fact being treated at home.
5. A question that does not provide a valid, assessable answer. The fact that there are OOH calls is indicative of the availability, and need to contact, the local GP. Whether there is an increase or decrease in the number of those calls depends upon demand and service satisfaction…but bares no relationship with inpatient community hospital beds.
6. A question that does not provide a valid, assessable answer. Again, 999 calls relate to emergency need, and possibly to dissatisfaction with the OOH service, but not to community hospital inpatient beds.
7. An expected result. Part of the pilot program was to keep patients in the acute hospital a little longer in lieu of the "step-down" facility at the community hospital. Therefore, it was expected that there would be such an increase.
8. The six-month evaluation showed an increase, however, the CCG subsequently added conditions (restricting the ages considered) which enabled them to claim that there was no change.

Notwithstanding the above, there are other risk factors that should be taken into account. With a heavy workload of around 10 to 1 (approximately 200 patients and approximately 20 staff) and a large, very rural geography, there are significant risks regarding distances and isolation. There could be a service failure due to a weather incident, or a vehicle mal-function, or staff issues such as sickness etc. There are also significant risks that any of these could cause a patient to be 'missed' at a crucial time.

Additionally, much of the area has little or no mobile phone or internet coverage. This exacerbates the risks to effective communication and support for both the patient and the "lone-working" community clinician.

Dr Tuckers' Review
In her review, Dr Tucker observes that the method of analysis used by the CCG carries the risk of masking trends, and creates a potential difficulty in referencing data and auditing the activity. She goes on to indicate weaknesses in each of the 8 elements, and that there was a need to admit 23 Torrington patients to neighbouring community hospitals (compared to 6 in the same 6 month period the previous year).

What about Sustainability?

The CCG's View
Throughout, the CCG have stated that the previous model (with hospital beds) was too expensive, and completely unsustainable. They have therefore provided the costs of the hospital bed operation, plus administration, building costs, therapy support, other patient services, and the general corporate overhead allocation to show how expensive the service was - £951,000 in total.

In comparison, they also provide the costs of the Torrington community services (or the 2Care at Home" staffing - £887,000. This indicates an over-all saving of £64,000.

	Hospital	**Community**
	(£000)	
Medical Staff	30	887
Inpatient Beds	519	
Total Inpatient Costs	549	887
Admin & Building Costs (Utilities, Rates & Maintenance)	117	
Therapy Support (from community services) & other patient services (pathology, radiology)	67	
Total Services including Building Costs	793	
General Corporate Overhead Allocation @ 20%	158	
Total	**951**	**887**

Commentary
In the "6 Month Evaluation Report" it is acknowledged that the cost of hospital staffing was an "ideal" projection for the full staffing requirements for 10 beds. The actual cost was much less, as an average of only 6.7 beds were used at any one time. So there has to be concern when the claimed saving is actually for "full" staffing that hasn't occurred for some years.

There are also a number of anomalies with the costs provided. The 'hospital' costs include many, acceptable, ancillary costs…but the 'community' costs stand alone. So what is the affect on the sustainability when these figures are adjusted for reality and 'like-for-like' presentation?

Whilst the hospital staff costs have been removed from the equation, those costs were not 'full' 10 bed costs, but 6.7 beds. The cost of the inpatient beds has gone, but the 'bricks and mortar' remain, as do rates and maintenance costs. I have also taken into account the minimum projected cost of operating the 'community hub' from the hospital building, the expected cost of 'spot bed' purchases from nursing and residential homes (a cost of £15k during the 6 month trial), and previous cost of the 'community team' (£504k) in the appropriate column.

	Hospital	Community
	(£000)	
Medical Staff (for 6.7 beds)	20	0
Inpatient Beds	519	0
Community staff	504	887
Total Inpatient Costs	1043	887
Admin & Building Costs (Utilities, Rates & Maintenance)	117	117
Therapy Support (from community services) & other patient services (pathology, radiology)	67	67
Community Hub costs (minimum projected)	0	100
'Spot bed' purchase (expected)	0	30
Total Services	1227	1201
General Corporate Overhead Allocation @ 20%	245	240
Total	**1472**	**1441**

This 'like-for-like' method shows that the 'new' service provision is at least as expensive as the previous service. When the stated reason for change is specifically down to costs, and where the original costs were unsustainable, how can the pilot be considered a success?

Also, it is difficult to assess where and why the savings come from, when there have been many efficiency savings brought in by the provider throughout the term of the test of change, as well as many other factors that have affected, and will continue to affect the statistics on local health.

Dr Tuckers' Review
In her review, Dr Tucker notes that the CCG's report claimed an annual saving of almost £250k, due mainly to the removal of hospital beds and staff, but including an unsubstantiated £80k that was projected to be saved as a result of a reduction in unplanned admissions, directly attributable to the Torrington model.

Is the Quality equal or better than before?

The CCG's View
The CCG claim in their 'Review of the Test of Change' report, that they have used "national and professional" documentation to ascertain the benchmark for service delivery, and the job descriptions of the different nursing staff for the evaluation.

They also promote the 'Friends and Family' test as a success. This test is offered to every person who has received the enhanced service from the therapists. It rates positive and negative scores, and has always been extremely sensitive to criticism. The score can range from +100 (everyone being positive) to -100 (everyone being negative). The aspiration was to achieve a score of +60, and the claimed achievement was +75. There was, however, only a 16% response (28 out of 174), which is 4% down on the national expected standard.

The CCG also claim that their community staff are completely satisfied with the new model of care. They have enhanced their clinical skills, developed additional capabilities and have a real belief and enthusiasm in what they are doing.

Commentary

Unfortunately, the reliance upon 'national' data is unsatisfactory, as it is by default divorced from local needs, conditions, geography, and demography, as well as being subject to frequent, and significant alterations dependant upon the 'political will' at the time.

There was no assessment made of the quality, satisfaction, success, or otherwise of the service provision prior to the test of change, therefore it is not possible to adequately judge whether the "new" service is the same as, better than, or potentially worse than before. What evidence there is from patients and prospective patients is heavy with worries, concerns, and dissatisfaction. However, as there was no collation of such commentary prior to the test of change, it is difficult to assess the value of these comments.

The 'Friends and Family' test will always be controversial as it requires patients, who are often worried about their future care, in the difficult position of putting that to risk by 'complaining'. A bit like asking Turkeys to vote for Christmas. Add to that the very low response and the validity of it as part of the assessment comes into question.

38 respondents to Health Watch Devon's 'Torrington 200 Survey' cited that they had experienced the new enhanced service, and all had concerns. This was dismissed by the CCG, and yet the 28 that responded to the 'Friends and Family Test' are promoted by the CCG as a crucially positive result.

The current community staff are responding that they are happy with the changes that have been made, and that some of them at least, have improved their skills. The previous hospital based staff, however, are far from happy. Despite promises that their jobs were safe, that NDHT would do everything possible to comply with their wishes, and that there would be no redundancies, there were very limited opportunities for them. A few transfers were available (but required significant travel), and whilst most of them expressed a wish to become part of the community team, none of them were allowed to do so. A number of them had no choice but to leave.

As previously observed, the opportunity to compare Holsworthy or South Molton (or both) as 'controls' that would have provided a reasonable indication of service quality and safety based on outcomes, is one that was sadly missed.

Dr Tuckers' Review

Throughout her report, Dr Tucker laments the lack of a comprehensive assessment of the service prior to change, and specifically that there are no reviews of the service provided in community hospitals. She also acknowledges that the key measure of service standards and quality was the comparison of the qualification of nursing staff, which was too narrow, and not quantified. She also complains that the CCG report section on service standards takes the form of a discussion rather then being evidence based.

Conclusion

It is surprising, and somewhat disappointing that the CCG should have ignored the inconsistencies in its information gathering. That they began the process badly, and were forced onto their back foot is not disputed. However, they never entered openly and transparently into proper dialogue/consultation/communication with anyone.

This 'aloof' attitude is further displayed by their insistence on claiming the Torrington pilot as a success. It is clear from the information *supplied by themselves* that it is far from conclusive. They have continually insisted, quite rightly, that any success would be reliant on the pilot proving that it was *'safe, sustainable, and of quality (equal to or better than before)'*, and yet none of the evidence actually proves any part of that claim.

In respect of safety, the evidence shows weaknesses in each of their specific assessment criteria, an increased risk to the elderly and vulnerable, and a variety of access risks, alongside the need to admit 26 patients to community hospitals during the 6 month trial (causing access difficulties to those patients and their loved ones due to travel issues).

Regarding sustainability, from the outset, we were told that the previous service was too expensive, and completely unsustainable. The 'like-for-like' figures indicate that there is, at best, a 'cost neutral' balance with the 'new' service, but with a number of costs still undetermined. This means that based on their own claims, the 'new' service can only be assessed as unsustainable, at the very best.

Even when we look at the quality of the service, the detail is disappointing. The CCG have assessed quality by the academia of their community nurses, based on national targets and policies, and have claimed that a controversial survey with an imbalanced response is enough to prove success. The local reality is that the public have continually voiced their objections, with surveys showing the dissatisfaction of the majority, and a local referendum resulting in an incredibly large turnout, and an overwhelming indication of public feelings with 99% against the CCGs proposals. The local GPs have also objected to the changes, and are not engaged with the CCG on this issue, and there is a mixed opinion from their own staff.

Added to this, the CCG have previously made a number of statements regarding the 'test of change' pilot that appear to show that they were pre-determined, and that they have 'made the evidence fit' rather than making decisions based upon what was evidenced. They attested that they did not need a 'snap-shot' assessment of the service prior to the test of change, that the bed closures were non-negotiable, there were hollow promises made to hospital based staff, and they stated their intend, throughout, to 'roll' the program out across the County (should it prove successful).

Recommendation

As a result of its studies, the task group recommend that the Health & Wellbeing Scrutiny Committee request that the NEW Devon CCG desist in their plans to replicate the Torrington experiment across the County, unless and until they are able to provide full and unequivocal evidence that such actions will benefit all patients and prospective patients, and that such a service will be safe, sustainable and of a quality equal or better than before.

And further, that the Health & Wellbeing Scrutiny Committee request that the NEW Devon CCG re-instate the inpatient services at Torrington Community Hospital prior to, and during, a complete review of the benefits, safety, sustainability and quality of the 'Care at Home' service in that locality.

Councillor Andrew Boyd

Electoral Divisions: All in Torridge

Local Government Act 1972

Contact for enquiries: Camilla de Bernhardt
Scrutiny Officer
Tel no: 01392 383143