Torbay and Southern Devon Health and Care NHS Trust

Community Hospitals – Briefing

Torbay Council Overview and Scrutiny Board

19th July 2012

1. Introduction

1.1 The purpose of this paper is to provide Council members with a briefing as requested outlining the function of the Community Hospitals, the services available and how these align and support transition from acute care to the Zone based model of care. The briefing will also provide an overview of any planned changes for 2012-13.

2. Community Hospitals in Torbay and Southern Devon

2.1 In April 2011 the "Transforming Community Services" reconfiguration led to the integration of health provision in the Southern area of Devon, including nine community hospitals with Torbay Care Trust. The integration of the nine southern community hospitals increased the number of community hospitals managed by Torbay and Southern Devon Health and Care Trust from two to eleven.These eleven community hospitals have 196 beds and primarily provide general medical services and are located in and comprise the following bed numbers:

Community Hospital	**Beds**
Ashburton	12
Bovey Tracey	10
Brixham	20
Dartmouth	16
Dawlish (PFI Hospital)	18
Kingsbridge	12
Newton Abbot (PFI Hospital)	35 (including 15 stroke)
Paignton	28
Tavistock	15
Teignmouth	12
Totnes	18
Total	**196**

Community Hospitals

2.2 The hospitals are open 24 hours a day, seven days a week. The hospitals admit, treat, rehabilitate and discharge patients.They provide a multi-professional team response that is focused on maximising the return to independence of patients through a short-stay inpatient admission (to either a community hospital or virtual ward); this includes health assessment, diagnosis and delivery of healthcare and support at a level of

quality that meets national and locally agreed standards. Patients are accepted either as a direct admission from a GP/health care professional/secondary care medical triage units, or as an early discharge/transfer from secondary care.

2.3 Newton Abbot Hospital also provides a specialist in-patient Stroke service. This provides rehabilitation for people with stroke and neurological conditions, together with specialist outpatient services and stroke aftercare.Patients are accepted either as a direct referral from a GP/health care professional/consultant or as a transfer from secondary care. Patients may self-refer to the outpatient part of the service.

Minor Injury Units

2.4 The Trust operates 10 Minor Injury Units (MIUs), one in each community hospital with the exception of Bovey Tracey hospital. The MIU service provides clinical assessment, examination, treatment and discharge or referral of adults and children over two years with minor injury and ailment conditions. The larger MIU's located at Newton Abbot and Paignton Hospitals are able to treat a broader range conditions. Patients may be referred by GPs and other health professionals or they may self-refer. In the last final year 55,000 MIU visits occurred during daylight hours.

Theatres

2.5 The Trust operates two theatres - on a staff and facilities-type basis - one at Tavistock and the other at Teignmouth hospital. The services and activity in both of these units is owned and provided by Acute Trusts. These include general surgery, orthopaedics, plastic surgery, dermatology and others.

Outpatients

2.6 All the community hospitals operate a wide range of therapy and outpatient services including in house as well as services provided from Derriford and South Devon Healthcare Trusts.

2.7 In general these services are located close to home to meet and serve the geography of our area. Transport to service is a key issue in most areas of Devon and Torbay, thus these services wherever feasible are located in the heart of communities.

3. Community Hospitals key numbers and performance

Occupancy

3.1 The 196 beds are used as part of the wider Health system in Torbay and Southern Devon to support NHS beds capacity in meeting patient need. Average bed occupancy stands at 88.4%, in a range between 76% and 96% (11-12). Our objective is to keep stays to a minimum and return patients to their home/community environment once they have been treated quickly and safely. In terms of primary diagnosis for patients in Community Hospitals the top five groups relate to minor injuries, problems with

circulation and breathing, cancer, poor renal function and musculoskeletal problems although a wide range of other diagnosis are treated.

Activity

3.2 During 2011-12 in the Community Hospitals 3,871 in-patients seen in the 196 beds across the 11 hospitals, 55,000 MIU patients seen and 125,000 outpatients seen.

3.3 Work has been undertaken recently to establish a daily bed management monitoring system as well as daily patient flow reporting processes and regular performance summaries. These systems which are community hospital orientated have been developed with the local matrons and provide a real sense of local ownership. This system means that services can be managed more effectively and objectives delivered more efficiently. All our resources endeavour to be flexible and remain in a state of readiness to respond to periods of pressure, for example during the winter period.

Cost

3.4 The combined budget of the Community Hospitals is £22.7 million.

Quality and Safety

3.5 Since February 2011 the Care Quality Commission (our external auditors /inspectors) have visited the following Community Hospitals: Ashburton, Bovey Tracey, Brixham, Dawlish, Dartmouth, Kingsbridge, Paignton and Tavistock. The key themes highlighting best practice from the feedback and reports received included:

- very high standards of cleanliness
- good systems in place to identify and manage any infections and to prevent these spreading
- hospitals combine technical excellence with kindness and that makes for first class nursing, Staff are extremely caring, kind and thoughtful, Staff are respectful of people's feelings and patients feel that staff listen to them
- Patients are given tasty and nutritious meals that suit them and which promote their health and well-being, the quality of meals is excellent and people are offered wholesome choices
- There are clear systems in place for people to understand how to complain about their care and treatment, if they wish

3.6 Patient's views are taken into account and they are supported to make choices, the ward environments are calm and well organised and patients feel safe and secure.

3.7 Some common themes have been identified that provide a focus for service improvement activities, these include:

- Safeguarding Adult procedures

- Mental Capacity Act and Deprivation of Liberty – awareness, training and obtaining consent

- Personalised care - planning to be demonstrated in documentation

- Documentation and clinical record keeping

- Clinical Supervision - the need for a consistent approach, purpose and structure

- End of life care - resuscitation and Treatment Escalation Plans

- Discharge planning - systems to ensure patients are discharged in a timely manner

3.8 The themes above are incorporated into Community Hospital CQC action plans. These are developed by matrons in collaboration with the Professional Practice and Operations Team. Matrons have accountability for delivering the service improvements identified in the CQC report.

3.9 Performance in national audits such as the Patient Environment Assessment Team (PEAT) assessments also provide an indication of the quality and safety of services. 7 of the 11 hospitals achieved a rating of excellent in all three PEAT measures, 4 Hospital achieved a mixture of good and excellent in all categories assessed including the environment, food and privacy and dignity.

3.10 The current challenges are:

- Patient complexity e.g. the impact of older age, co-morbidities and dementia in patients will require the development of new care pathways to support people in a range of care settings

- Minor Injury Units –There is difficulty in sustaining staff competencies in some of the smaller units where activity levels are very low and the potential need to agree a realignment of the operating hours

- The need to deliver the financial savings targets will require significant redesign of services

- The acute hospital have achieving one of the lowest lengths of stay in the country, we need to be able to support them in ensuring there are no delayed discharges. Managing whole system capacity demand and ensuring the continuity of our day to day business

- The changing needs of patients will require us to review some services in relation to clinical care pathways requirements

- Recruitment and retention of staff especially to services where exposure to certain clinical experiences are limited but will be will be necessary to retain competency levels and registration.

4. Interaction with Community Zone Teams and Acute Hospitals

4.1 The Community Hospitals have a key role in the delivery of the whole integrated approach to Health and Social Care provision for our community.

4.2 This ethos is best summed up in our approach of the “Right care, Right place, Right time” with our client/patient “Mrs Smith” always placed in the centre of the activity, based on her needs and the needs of her family.

4.3 The health system uses a “Clinical Pathway” process (Stroke Care and Falls for example) which takes the patient on a journey from admission to the Acute Hospital when ill and requiring urgent treatment, followed by placement for rehabilitation in a Community Hospital once the patient’s condition is stabilised. When ready for discharge home the Zone Team will arrange community support services such as Domiciliary Care to maintain Mrs Smith’s independence in the Community. If a patient requires other services such as long or short-term residential care or nursing home placements, the Health and Social Care Zone team will assess the client/patient and will arrange such services as may be necessary.

4.4 In all of the above activity the patient’s GP has a key role at all stages and works closely with the Community Hospitals and Zone teams to ensure the patients have good outcomes. Some Community Hospitals are GP led so will be a regular visitor to the wards to assess the patient’s condition and progress. Once discharged from the hospital, the GP’s role continues as they too work closely with the Zone’s Health and Social Care team.

4.5 Our Health system is committed to prevention with an aim to return patients safely to their community setting. The Zone teams approach in Torbay and Southern Devon is to deliver joined-up care in a seamless fashion across all boundaries. The Zone teams have a track record of providing integrated care with a single point of contact for GPs to coordinate care and to work closely with our acute hospital services at the South Devon Healthcare Trust. The teams serve a combined population of 385,000 centred around 11 localities in Torbay and Southern Devon. These teams include Social Workers, GPs, Occupational Therapists, District Nurses and others. Our person-centred approach aims to improve access, provide appropriate responsive care and eliminate Mrs Smith being passed around between different professionals. The various multi-disciplinary teams are well placed to deliver this model of care.

4.6 The impact of this approach has been evidenced as being very successful. We have a much lower bed day usage per 1,000 of the population than average for the South West and thus have very few delayed discharges. We have also reduced long-stay Residential and Nursing home placements.

5. Future challenges

Ageing population

5.1 Planning for the future presents a number of challenges for Community Hospitals. Clearly, we face an ageing population in a context where people rightly expect to be able to make choices about where they receive their care. The population of the Torbay and Southern Devon area is in the region of 375,000. 23 % of the population is over 65 years old, which is a higher percentage than the average for the rest of the country. 8% of the population is also over 75 years old and 4% over 85 years old, again above the national average.

Financial challenges

5.2 Financial resources are finite and the NHS is required to deliver £20 Billion savings targets across its service over the by 2014. There are many examples of care systems that meet the needs of the organisation rather than the needs of the patient. The savings plan is driving a review of all NHS services with critical appraisal of how they benefit the patient. This will lead to changes to care pathways and ensure patients are at the centre of care.

Technology

5.3 Technology is changing the way we deliver services, providing us with great opportunities on how the community interacts with us. Tele-health is a reality that allows patients to be monitored and managed in their own home. There are now examples of where Tele-health has allowed the patient with a long-term condition to remain in their own home but with daily contact with the specialist nurse or GP. This will reduce the need for bed based care.

Workforce

5.4 The workforce profile is also changing with the average age of NHS employee increasing. Staff have a greater range of opportunities than in the past and this leads to increasing competition between employers to recruit and retain staff. The move towards more care provision in the community will require staff to develop new skills and competencies to ensure they are fit for the future.

Increasing complexity

5.5 In the clinical arena, care will become more complex with the increasing age of our patients (80-90's) who have a number of medical conditions e.g. dementia, long-term conditions such as diabetes, strokes, falls and mobility problems. We need to continue to provide safe services in quality environments in order to meet our customers' expectations and especially their privacy and dignity rights. Keeping patients flowing through the system and maximising the use of our resources will remain central to our ability to deliver effective and efficient services.

Increasing community based care

5.6 There is a clear national and local consensus that more services will be delivered in people's own homes with less reliance on hospital or other residential beds. It is anticipated that initiatives such as personalised budgets will drive this change in approach much further. Service/opening hours may need to extend and this in turn will have many operational implications.

5.7 We will need to think through a range of issues linked to rurality, isolation and transport and the quality and location of our estate. The current financial climate and the drive for further cost effectiveness and efficiency will over arch all of the challenges alluded to above.

5.8 Community Hospitals can be and will remain a key component in our provision but they will need to evolve to be an integrated part of care communities delivering services in or closer to Mrs Smith's home.

Summary

5.9 The newly established Torbay and Southern Devon Health and Care NHS Trust is now a provider only organisation following the approval of the Health and Social Care bill. The Trust's area is diverse with both rural and urban dimensions, with a large Older Persons population. As a provider beginning its life in an environment of on-going public spending constraints we have a duty to ensure we balance the quality of our services and value for money so that our Community Hospitals are well regarded by the locality and perceived as efficient in our use of limited resources. The public are familiar with these circumstances given that the general environment of austerity is now a well-established requirement. As referenced above, for some years the direction of travel in National Health and Social Care policy has been to move away from the provision of hospital beds towards the provision of community and preventative services. The Trust has operated an integrated health and social care model in Torbay in partnership with the Local Authority since 2005. This has been recognised nationally as a model of good practice and any future change would indeed retain these stated principles.

5.10 Any changes that may be planned on the provision of services in Community Hospitals in future will be reported at an early stage to the Health and Wellbeing Scrutiny committee as well as including appropriate consultation channels with relevant stakeholders. It should also be noted that in the new arrangements in the NHS currently being implemented that the new Commissioning Bodies (CCG's) will lead any service change and that the implementation will be the duty of the provider of services. However, this will in reality occur in partnership with our commissioners in order to deliver the desired outcomes in the best interest of and in response to changing local needs.

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