Community Hospitals Association

Response to the NEW Devon Clinical Commissioning Group Consultation Document

"Your Future Care"

> *"People have a right and duty to participate individually and collectively in the planning and implementation of their health care."*
> Alma Ata WHO 1978

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1. Introduction

The Community Hospitals Association

The Community Hospitals Association (CHA) is a membership organisation for England, Wales and Northern Ireland. The CHA advises on community hospitals and services, and regularly contributes to strategies and service planning, as well as commenting on consultation documents. The CHA has read and analysed the plans for community hospitals in Eastern Devon in the NEW Devon Clinical Commissioning Group (CCG) consultation document, "*Your Future Care"* and has prepared this response. The CHA has also been invited by local community groups to provide a response. The CHA is in regular contact with those concerned with local health and social care across Devon. The CHA has considered the document, and spoken with local people in Devon. We trust that our comments are helpful. We would be pleased to provide further information as required.

"Your Future Care" Consultation Document Issued by NEW Devon CCG

The document "Your Future Care" is NEW Devon CCG response to the Success Regime report "Case for Change" February 2016. The consultation period on this report is from Friday 7th October to Friday 6th January.

"This consultation is therefore about how we decide the location of fewer community hospital inpatient beds in Eastern Devon." (Your Future Care)

The consultation document proposes to reduce the number of community beds from 143 to 72, and reduce the number of locations for community beds to just 3 of the 12 community hospitals.

The preferred option (A) in the document is a configuration that has 32 beds in Tiverton community hospital, 24 beds in Seaton Hospital and 16 beds in Exmouth hospital.

Options B, C and D provide combinations that consider Sidmouth (rather than Seaton) or Exeter (rather than Exmouth) hospitals. Option E is an additional 5th option in which the public can put forward an alternative proposal as free text.

The CHA has considered the model of care, options in the consultation document, and the consultation process.

2. Executive Summary

This report sets out the Community Hospitals Association (CHA) review of the NEW Devon CCG consultation document *"Your Future Care"* which sets out its proposals to close many community hospital beds across rural Eastern Devon. This review identifies inaccuracies, and a lack of applied evidence from research particularly on community hospitals. The CHA questions the underlying assumptions made that shape these proposals.

The CHA proposes a pause in the process, to allow for corrections and clarifications, consider more evidence from research and evaluations, undertake a genuine consideration of invited alternative options, and carry out further planning with each of the affected communities.

The CHA believes that the proposals, if implemented, would have a detrimental effect on individual patients, communities and the whole health system, and will not achieve the planned outcomes, including making substantial financial savings. The proposed reduction of services from 143 to 72 community beds to be retained in only 3 of the 12 community hospitals is a significant loss of service and compromises local community capacity for valued intermediate care. This reduces the choice for care closer to home for patients. The level of provision is based on a formula of 1.9 beds per 10k population, which is significantly less than other comparable rural health areas, and there is a lack of supporting evidence to demonstrate that this reduced ratio is appropriate or sustainable. The 4 options are fixed on a configuration of 3 locations having 32; 24; and16 community beds respectively. The CHA would question how this configuration offers care closer to home according to Government policy and in particular the CHA would question the decision to have 32 beds in one location, and only have 3 community hospitals retaining beds in such a rural area.

The CHA has analysed the option appraisal, and we have commented on the range of options, the criteria, and the way that the options were scored against criteria. This review identified inaccuracies, and the use of incorrect postcodes for 6 of the community hospitals in the option appraisal. This was a mistake that was significant as 2 of the 6 criteria used were measuring location and distance to determine ease of access for patients and carers. This is a fundamental error that we understand has reduced local confidence and trust in the process overall. We understand that these errors have been corrected retrospectively, but there is still a need for the CCG to demonstrate which postcodes were used in the appraisal.

The CHA has identified issues with the scoring system, which, if pursued, would make a case for Honiton and Okehampton hospitals to be reconsidered for retaining beds.

The CHA has concerns about the principles underpinning these proposal, including the assumption that closures of community hospital beds will save money for the health economy overall. The model is based on the Torrington Test for change, which has continued to be challenged at a local and national

level. It is essential that evidence from closing community beds elsewhere in Devon, and across the UK and internationally is considered. It is important that the proposals to demonstrate an evidence-base for the changes, learning from research and evaluations nationally and internationally. The CHA has provided some references and links for this in this response.

The CHA has considered how NEW Devon CCG addresses the requirement to address how patients and families who will be disadvantaged by these proposals will be catered for, how their concerns and anxieties met, and how any potential difficulties mitigated. The CHA has concerns that there is insufficient attention to arrangements for those who may not be cared for in their own homes if their local community beds close. The CHA recommends that further work is conducted including auditing inpatients by acuity, treatment plans, and holistic care needs may help to identify the cohort of patients who will continue to require local 24 hour inpatient care, such as those who have rehabilitation as a step towards returning home, or as those having care at the end of their life.

Whilst the CHA supports the direction of the new model of care in terms of offering more care to more people in their own homes, we are concerned about the balance of provision between care at home and care in a local hospital. The CHA is concerned that the proposals do not appreciate the role of community hospital inpatient care for supporting complex patients and patients who require end of life care close to home has not been appreciated and there is insufficient information on the current model of care and its impact.

The CHA believes that the consultation process can be challenged. The consultation process is not in keeping with the direction given to Devon County Council by the Chair of the Independent Reconfiguration Panel (IRP) in response to their referral to the Secretary of State for Torrington Community Hospital. We have heard views locally that there was insufficient pre-consultation planning locally, and that the announcement of the consultation on bed closures was a shock to many concerned. The CHA is concerned that the process is not inclusive, as those living in communities such as Honiton or Okehampton have not been given any options around their local services, but rather a decision has already been made prior to consultation to close beds in their hospitals. A further concern, raised at public meetings, is how additional options, invited as a 5th option in the consultation, may be developed, tested and consulted upon. It is hoped that due consideration is given to alternative options, and that consultations are given to all communities. Once a favoured configuration is agreed, it is hoped that a phased implementation is planned to enable ongoing evaluation to be carried out, particularly of the impact on individual patients, families and carers, social care and the whole healthcare system.

In conclusion, the CHA believes that the proposals in respect of the underlying assumptions, the principles and the option appraisal can be challenged. The CHA is concerned that the proposals have not benefited from being informed by sufficient research evidence and evaluations. The CHA believes that the consultation process does not meet the requirements of the NHS by failing to

give a voice and a choice to each of the affected communities. There is no evidence of local planning in a model of co-production.

The CHA suggests that there is a case to be made for agreeing a **"pause"** in the process, whilst further work is carried out for clarification, correcting data and sharing learning from evaluations, research and best practice. In particular the CHA would suggest that there is:

- Local planning with each of the seven communities affected
- A revisiting of the assumptions, options, and option appraisal, with improved accuracy of data including access and finance
- A consideration of alternative options submitted by the public at the invitation of the NEW Devon CCG, which allows time to test, develop and consult on these options
- Further work to share outcomes of evaluations of the impact of community bed closures to date, and to draw from evidence from research on community hospitals and models of care internationally
- A process for designing a gradual and phased implementation plan aligned to the STP timetable with on-going evaluation and a Gateway process

The work identified within these recommendations including working with each community and across the whole health system would suggest a period of no less than six months. There is much at stake for rural communities, and the scale of the adverse response from local people across Devon would suggest a lack of confidence in the consultation, both in terms of content and process. Community hospitals are valued and trusted by local people, with a long tradition of care and with significant support from communities. The CHA would urge the consideration of a pause, to enable further work before final decisions are made.

3. Proposed Reduction of Community Beds

The CHA has considered the documentation and spoken to local people. We have drawn from our knowledge of research and best practice, and utilised our networks.

The CHA has concerns that the role, function and benefit of community hospital services have not been fully appreciated by the CCG within the document. Local people are concerned that the CCG does not recognise the value and impact of local inpatient beds, and are concerned for the specific cohort of patients, and their families that will be affected by these proposals.

The proposal is to reduce the number of community beds for Eastern Devon to 72. In 2012, there were 244 beds. This is a dramatic reduction that is understated in the papers.

In 2012, 12 communities benefited from fully functioning community hospitals with inpatient wards. In July 2015, a decision was taken at NHS Northern, Eastern and Western Devon Clinical Commissioning Group's (NEW Devon CCG) Governing Body meeting *"Community hospitals at Axminster, Crediton and Ottery St Mary will no longer have overnight inpatient beds, although Ottery St Mary Hospital will have 15 overnight stroke rehabilitation beds for now. None of the community hospitals will close as a result of the decision."* Ottery St Mary continues to have stroke beds and community beds and it may be argued that Ottery St Mary Hospital is continuing to provide a valued inpatient care function. (NEW Devon CCG websitehttp://www.newdevonccg.nhs.uk/about-us/latest-news/2015-news-archive--/july-2015/101777)

In the future, only 3 communities will have community beds in their local hospitals that are accessible to them. 9 communities, who have had the benefit of locally accessible inpatient services, will no longer have access to this service. The range of locally accessibly intermediate care services will be reduced, and community capacity for local health and care services is reduced.

Community Hospital	**Beds 2012**	**Beds 2015**	**Current Beds 2016**	**Proposed beds 2017 Option A**
Axminster Hospital	18	0	0	0
Budleigh Salterton Hospital	12	0	0	0
Crediton Hospital	12	0	0	0
Moretonhampstead Hospital	9	0	0	0
Exmouth Hospital	30	30	18	24
Honiton Hospital	18	18	18	0
Okehampton Hospital	16	16	16	0
Ottery St Mary Hospital	18	0	3	0
Seaton Hospital	18	18	18	16
Sidmouth Hospital	18	18	18	0
Tiverton Hospital	36	36	32	32
Exeter Community Hospital Whipton	39	39	20	0
	244	175	143	72

Table 1: Inpatient bed numbers in Community Hospitals in Eastern Devon 2012 to 2016, and proposed 2017

This table shows that in 2012, all 12 community hospitals had beds. At the time of this consultation, 4 community hospitals have already lost beds. A further 5 community hospitals will lose beds under these proposals. This will have a considerable impact on rural communities, and their access to local inpatient care. Across Eastern Devon, there will be only 3 of the 12 community hospitals retaining their community beds.

A principle underpinning the plan is that the number of community beds should be equitable with Northern Devon, at 1.9 beds for 10k population. This may be challenged. This is lower than other comparable areas (see Table 1 below). For instance neighbouring South Devon and Torbay will provide 3.25 beds and Cumbria (another Success Regime) plans to provide 2.55 beds for 10k

population. If the South Devon and Torbay ratio were applied to Eastern Devon, there would be 130 beds provided. Even if Eastern Devon had one additional 16-bed ward retained, there would still be fewer beds per population than these other areas. Further work may be done to benchmark this provision. Given that the service re-design is based on this premise, it would be prudent to research this more fully and consider whether this level of provision would be sufficient for current and future need. It is recommended that national and local research would contribute to a re-evaluation of the community beds required.

Area	Beds	Population	Beds per 10k pop
Northern Devon	32	165,790	1.93
Eastern Devon	72	389,370	1.85
Western Devon	72	352,460	2.04
South Devon and Torbay	93	286,000	3.25
Cumbria	84	330,000	2.55

Table 2: Beds per 10k population in a Sample of Health Economies

4. Appraisal of Which Community Hospitals Retain Beds

The option appraisal carried out on which community hospitals did not appear to take into account the current range of services at each hospital, and which was a good strategic fit with the services already in place.

A number of principles were established before the option appraisal took place.

- Only 3 of the 7 community hospitals would retain beds
- That there would be a total of 72 community beds
- Tiverton would remain as a community hospital with beds
- Tiverton Hospital would have 32 beds
- The configuration of beds would be in 3 locations: 32 beds, 24 beds and 16 beds.
- Only 2 of the community hospitals would have the option of 24 beds – Seaton or Sidmouth.
- 6 of the hospitals would be considered for keeping inpatients beds with 16 beds.

It may be pertinent to revisit these principles, given the challenge to the overall level of community beds for the population, and the concentration of these beds is just three locations in rural Devon. For instance there is a case for retaining beds in 4 community hospitals, and adjusting the ward sizes accordingly. The value of having a concentration of 32 beds in one locality may be questioned. The removal of Ottery St Mary from the option appraisal, which currently has both community beds and stroke beds, may also be challenged. Arguably there are 8 community hospitals with beds that could continue to provide inpatient care.

- **Options**

The CCG has set out 15 options. However, 5 of these options are for a combination of hospitals that includes Exmouth with 24 beds. This has been shown to be neither feasible nor affordable. Therefore 10 options were given serious consideration in the option appraisal.

- **Criteria**

The remaining 10 options have been measured in the option appraisal by 6 criteria: Quality, Implementability, Patient Access, Finance, Carer Access and Whole System Impact.

The 5 levels of scoring were graded from Lowest; Low; Neutral; High and Highest. It is not clear whether these 5 levels of scoring were given a numerical value, and if the low evaluation scores were given a negative value. However if an option has a negative score on one of the criteria, it has still been considered as an option and not discounted on that basis.

The 10 options scored "Highest Evaluation" level for 4 of the criteria: Quality, Implementability, Patient Access, and Finance. Therefore only 2 of the criteria had any impact on the decision-making. These were: Carer Access and Whole System Impact.

Options 1-5	**1**	**2**	**3**	**4**	**5**
Tiverton (32) & Seaton (24) plus:	Sidmouth 16	Honiton 16	Exmouth 16	Exeter 16	Okehampton 16
Carer Access	xx	=	=	yy	xx
Whole System Impact	x	=	y	xx	x

Table 3: Options for 16 bed facility, to add to Tiverton (32) and Seaton (24)

Options 11-15	**11**	**12**	**13**	**14**	**15**
Tiverton (32) & Sidmouth (24) plus:	Exmouth 16	Honiton 16	Seaton 16	Exeter 16	Okehampton 16
Carer Access	xx	=	xx	yy	=
Whole System Impact	y	=	x	xx	x

Table 4: Options for 16 bed facility, to add to Tiverton (32) and Sidmouth (24)

3 of the 4 options that the public have been asked to consider have scored the lowest negative score for either carer access or whole system impact. However, options that have no negative impact on these two criteria have not been put forward.

The CHA has tested the scoring of the criteria to assess which would provide the clearest measure. Option 3 of the options is shown to be the option with the highest score or value. However, there are other options that score very closely that have not been considered, such as those with Honiton hospital as an option with no negative impact.

Option	Summary by CCG	CHA Comments
1. Seaton & Sidmouth	Negative scores for both access for carers and whole system impact	
2. Seaton & Honiton	Neutral scores for both access for carers and whole systems impact	*Neutral scores – no negative impact therefore consider option?*
Option A **3. Seaton & Exmouth**	Preferred option to explore- positive score on whole systems impact and neutral score on access for carers	
Option C **4. Seaton & Exeter**	Option to explore – highly positive score for access for carers	Negative score for whole system access (xx)
5. Seaton & Okehampton	Negative scores for both access for carers and whole system impact	
Option B 11. Sidmouth & Exmouth	Option to explore –positive score on whole systems impact	Negative score for access to carers (xx)
12. Sidmouth & Honiton	Neutral scores for both access for carers and whole systems impact	*Neutral scores – no negative impact therefore consider option*
13. Sidmouth & Seaton	Negative scores for both access for carers and whole system impact	
Option D **14. Sidmouth & Exeter**	Option to explore – highly positive score for access for carers	Negative score for whole system access (xx)
15. Sidmouth & Okehampton	Neutral score for access for carers and negative score for whole system	

Table: 5 CCG appraisal of options (column 1&2) with additional column for HT comments Source: CCG Pre-business Case

The CHA would recommend that the principles underpinning the option appraisal are re-visited. There is a case for 4 locations, 88 beds, and a different mix of 24 and 16-bedded wards. The number of hospitals considered could be increased from 7 to 8 to include Ottery St Mary as this is a community hospital which continues to provide community inpatient beds including beds to support people who have had a stroke.

There is a case for reconsidering the criteria, to include considerations such as levels of community support through subsidies and volunteers, patient experience and satisfaction measures, outcome measures, current condition of the ward and equipment and staffing levels skills and experience. There is a concern that the appraisal has not been sensitive enough to each community hospital and its strength, weaknesses and potential. The CHA questions the validity of the option appraisal, which appears to give the public more choice that it actually has. The CHA welcomes the addition of the fifth option, which communities can design themselves. We trust that all options will be given careful consideration.

5. Access and Distances

The working papers in the pre-consultation business case concerning modelling travel distances has been scrutinised by the CHA. Inaccurate postcodes have been utilised for 6 of the community hospitals. Given that 2 of the 6 criteria are concerned with access, this inaccuracy is of major concern. This may be considered as discrediting the process, and has raised concerns about the accuracy of the rest of the data.

Community Hospital	Carnall Farrer Reported Postcode	Actual Postcode	Difference in Distance in Miles	Distance in Travel Time
Exeter Community Hospital (Whipton)	EX1 3RB	EX1 3RB		
Exmouth Hospital	EX8 2JN	EX8 2JN		
Honiton Hospital	EX22 6JQ	**EX14 2DE**	**65**	**1 hour 15 mins**
Okehampton Hospital	EX14 2DE	**EX20 1PN**	**42.3**	**46 mins**
Seaton Hospital	EX20 1PN	**EX12 2UU**	**46.8**	**1 hour 3 mins**
Sidmouth Hospital	EX12 2UU	**EX10 8EW**	**9.4**	**19 mins**
Tiverton and District Hospital	EX10 8EW	**EX16 6NT**	**34.1**	**44 mins**
South Molton Community Hospital	EX36 4DP	EX36 4DP		
Holsworthy Community Hospital	EX16 6NT	**EX22 6JQ**	**45.6**	**1 hour 16 mins**
Mount Gould Hospital	PL4 7QD	PL4 7QD		
South Hams Kingsbridge Hospital	TQ7 1AT	TQ7 1AT		
Tavistock Hospital	PL19 8LD	PL19 8LD		

Table 6: Your Future Care Pre-Consultation Business Case Appendix 17.1: Travel Model with Corrections by CHA on postcodes

The CHA questions the validity of the option appraisal, given that incorrect postcodes were used. One of the 2 criteria impacting on the decision-making was “carer access.” Therefore it is critical that this exercise is carried out accurately, and that patient and public confidence is restored.

The CHA understands that once these errors were identified to the CCG they were corrected retrospectively, but we understand that there is still a need for the CCG to demonstrate which postcodes were used in the appraisal.

- **Learning from Consultations Nationally**

We would draw attention to the experience in Derbyshire where 3 tables of financial data were published as part of the consultation documentation were found to contain material inaccuracies, Each of the tables overstated the actual cost of the community hospitals. A formal apology was published, and a “clarification” period of one month was added to the consultation period.
http://www.joinedupcare.org.uk/come-and-meet-us/upcoming-events/list/2016/consultation-clarification/

A clarification form was available for download which showed the corrections. Those being consulted had an opportunity to study the figures and then complete the form to say whether the new accurate information had made any impact on their previously submitted response to the consultation.
http://www.joinedupcare.org.uk/media/44039/better-care-closer-to-home-clarification.pdf

In addition to the apology, a youtube video showing clearly the extent of the mistakes made was publicised. https://www.youtube.com/watch?v=U8O-wvAJoNE

It may be helpful to learn from the experiences of others in respect of mistakes made in data utilised in option appraisals, and steps that may be taken to establish confidence in the process.

The CHA questions the credibility of the option appraisal, and the consultation process. We understand that local people view **their** local hospital as a facility that they have a responsibility for, and how they have supported their local hospitals as local assets over the years through subsidies and volunteering. We would hope that this would be recognised, and further work carried out with each of the 12 communities to find a solution that meets their local needs.

The critical decision that determines the fate of all of the community hospitals in East Devon is the decision to retain beds in Tiverton Hospital. It is understood that this is not for reasons of access, patient need or range of services but is because of the PFI contract and the on-going lease agreement. So retaining beds Tiverton Hospital as one of the three required is not open to consultation. There is also an assumption that the beds in this hospital will be 32, and this is not a variable in the option appraisal. The only variables in the 4 options that the public are being asked to consider are whether to retain 24 beds Exeter or Exmouth Hospital, and whether to retain 16 beds in Seaton or Sidmouth Hospital. We would question the assumptions underpinning this.

6. Potential Impact on Patients

The CHA believes that there is a lack of attention to the specific cohort of patients who will be affected by the reduction in the local inpatient service. This is contrary to the response from the Independent Reconfiguration Panel (IRP). The IRP wrote, following the referral for consideration of a review of the Torrington proposals. *"A key lesson from Torrington is to be clear and specific about which patients will likely continue to need inpatient care and how their needs will be met in the future." (IRP communication re Torrington)* It is understood from the acuity audit that the patients currently being given 24 hour clinical care in a community bed average 81-83 years of age. Typically these patients have multi-morbidity. It is not clear how their needs will be met in the future.

It is clear that this proposal heralds a change in the role and function of community hospitals in Devon. Whilst in many areas they are considered to be small, locally accessible hospitals, in Devon the question of whether they are hospitals (without beds) or local (taken away from many communities) needs to

be debated. The IRP advised the CCG that it is prudent to be clear about the negative impact of the change to a cohort of patients, and to indicate what steps the CCG is taking to mitigate against these changes. *It is necessary to be up-front about the realities and trade-offs of service change." (*IRP communication re Torrington).

"A key lesson from Torrington is to be clear and specific about which patients will likely continue to need inpatient care and how their needs will be met in the future. Particularly in a rural setting, travel and access will always be a significant concern even if only for a relatively small number of people. Recognising such concerns, and where possible mitigating for them, will help to calm local anxieties and build confidence."

The utilisation of the inpatient beds is another factor that is open to misinterpretation. To those reading the consultation document, an average occupancy of 90% (confidence range (90%-97%) would suggest that these beds were being well used. This occupancy is greater than the national guidance of 85% occupancy for patient safety and infection control. However the consultation document refers to under-utilisation.

The Devon Acuity Audit 2015 identifies patients in both acute hospitals and community hospitals that have successfully had their clinical assessment, treatment, intervention or rehabilitation and have been assessed as being ready to leave hospital. The most common reasons for patients waiting to be discharged is that there are delays in planning their safe discharge and arrange for arrangements such as care packages and equipment etc. There appears to be little logic in concluding from these facts that the way to solve this problem is to shut the beds. The service offered in the community hospital has achieved its aim of meeting the patients' needs. The issue is support on discharge. Given the acuity and age of patients, and for many their complex care needs, sensitive discharge arrangements need to be in place. It has been argued that this is best carried out from a community hospital, where hospital staff can work closely with local community teams. The delays are understood to be predominantly social care packages, and it is difficult to understand how this issue will be resolved through the closure of community hospital beds.

The document states contentiously that *"40% of patients never get back home",* (page 10) which is an implied criticism of failure of the service. The Acuity Audit 2015 states that 60% patients are discharged to their own homes. The nationally published mean is 67% for community hospital beds. Clearly this performance needs to be assessed in the context of the patients in the hospital beds. Community hospitals offering end of life care, for instance, should not be considered to have an adverse performance because a proportion of patients do not go home. It is also difficult to consider this fact as a reason for closing the beds, given the acuity of the patients and the reasons for admission.

It would be helpful to have a more detailed commentary to the Table on page 16, which sets out interventions that patients needed. The table appears to show that of the 254 requiring basic care, 145 needed care overnight, only 135 needed

further physiotherapy. The table would benefit from a title, source and a more detailed commentary as to the interpretation of the figures. It has already been established that some patients are ready to be discharged from acute hospital beds and community hospital beds. The numbers of patients requiring OT and physiotherapy again will be determined by their care plan. For instance, a patient may be an appropriate admission for end of life care, and may not need access to services such as physiotherapy and occupational therapy. There are also further explanations about patients requiring 24-hour care, and how they may be catered for if the beds were closed.

7. Potential Impact of Change Overall

There is an assumption that there will be no compulsory redundancies, as staff will be redeployed (page 32), and that this will be addressed in a Workforce Strategy. This will also be issued subsequently. Options may be redeployment in the community or in neighbouring organisations. It is hoped that the local NHS does not lose valuable talent, expertise and experience through staff leaving the service because of this fundamental change in their jobs.

The point is made that inpatient stays "*stays in hospital can expose patients to the threat of hospital-acquired infections.*" (page 14). We would be interested to know about the rate of hospital-acquired infection in community hospitals as compared to acute hospitals. Our understanding is that this is more of an issue for acute hospitals.

It would be helpful to have more information about how the calculations were made for the different models of care. For instance, the community hospital staffing costs are only nursing, and it is shown for the same amount, patients would benefit from therapists, support workers as well as nurses. But patients in community hospitals also benefit from therapists etc. The implication is that the money would be used to fund a wider team. Again, there is no consideration for the acuity of the patient, and in particular for those patients who could not be cared for at home.

8. Considering Research Evidence

There is a concern about bias within the document with regard to evidence. For instance, much is made of the outcome of the Friends and Families Test for care at home, but no equivalent information is shared on community hospitals (P19). The Friends and Family Test score quoted is between 95% and 100%. Similar scores of 90% and over are recorded for community hospitals on the NHS choices website. Updated scores of community services and community hospital services would be of interest and provide a more balance picture of patient satisfaction.

The report quotes a recent research study by Professor Glasby which explored the issue of preventing avoidable admissions, and the report identified that although there was evidence of trying to avoid admissions, the ways into home-based community services were sometimes complicated (p10). The main point of his study however, was that when interviewed, 91% of patients stated that they believed their admission into hospital to be appropriate. 9 patients (9%) said that they did not believe that they needed to be in hospital, but doctors disagreed and felt that their admission was entirely appropriate. Therefore all admissions studied were appropriate. Whilst it is helpful to quote the Glasby study, it would have been more helpful to focus on the main findings.

There is an assumption that the closure of community beds will make savings for the health economy. Research studies have demonstrated that community hospital beds provide a model of intermediate care as viable models, and in countries such as Italy and Norway there is an investment in this model of care.

There is much research evidence of the benefit of community hospital inpatient care in terms of cost, efficiency and patient experience.

> The overall findings of the RCT that this study links with confirms that the community hospital meets the requirements of evidence-based care and cost-effectiveness. It also achieves patient approval. We identify a model of community hospital care that incorporates technical aspects of rehabilitation within a human approach that is welcomed by patients. (Small *et al*. 2007).

Internationally, there is attention being given to developing this model of care, in order to alleviate pressure on acute hospitals. A recent research paper from Norway has said about its MAUs (intermediate care beds)

> "Introduction of MAUs following implementation of the Norwegian Coordination Reform in 2012 was associated with a significant reduction in hospital admissions primarily for the elderly. Our findings suggest that this type of intermediate care is a viable option in an effort to alleviate the burden on hospitals by reducing the acute secondary care admission volume." (Swanson et al 2016)

A major research programme involving three large teams of researchers is due to report on findings next year, and these studies will be pertinent to the current decision-making. The case has been made to the Health Select Committee that there should be a pause in decisions about closing beds in communities until this National Institute of Health Research (NIHR) programme has published. This includes a study led by Professor John Young at the University of Leeds on cost-efficiency, a study led by Professor Jon Glasby at the University of Birmingham on community value and patient experience, and a study by Ellen Nolte with RandEurope and the University of Birmingham on international learning.

In one of the papers recently published the authors conclude that *"community hospitals have a key role in integration within their local healthcare system"* (Winpenny et al 2016).

The research evidence on the impact on communities of the closure of local rural community beds is highly illuminating. The CHA tracks changes in community

hospitals, and record any closures of inpatient provision and also closures of community hospitals. From experiences in Canada regarding closure of rural hospitals, researchers described the loss of beds from a community hospital (or the closure of the hospital) as a "*critical incident*" for the community, with a wide impact overall with devastating repercussions beyond health. An appreciation of the research evidence may help in the management of change and the steps to be taken in the removal of rural services. (Petruka et al 2003).

There is further information and resources on the CHA Research website
http://www.communityhospitalsresearch.org.uk/index.html

The support for local community hospitals services across Devon is very strong, and this is clearly to the credit to the local NHS. Community hospital services, and in particular the inpatient beds, are valued and trusted by their communities. In some areas, such as Surrey and East Sussex, they are increasing their community bed provision as a way of addressing their need for local community capacity: *"Agreement has been reached across the STP that an increase in capacity is needed in community beds."*

The consultation process has brought to the fore the strength of feeling by local people, which we hope will be listened to.

9. New Model of Care

The model of care described shifts much of the clinical care and support to patients within their own homes. Investing in integrated community teams is to be supported, and has been shown elsewhere in the country to be a model which optimizes patients rehabilitation and increases patient satisfaction and outcome. However, there is a question of balance in the range of intermediate care services within a locality, acknowledging the need for patient selection and the option of local inpatient care for some patients who cannot be cared for safely or appropriately at home.

The new model is based on the Torrington Test for Change, when beds were closed at Torrington Hospital. The loss of the service has instigated public campaigns, and has involved, amongst others, the local MP, Secretary of State for Heath, and the Independent Reconfiguration Panel. The evaluation of the Test of Change was over the first six-month period, which was acknowledged as too short a period to establish a new way of working. The Torrington pilot continues to be challenged. It would be helpful to share the evaluations of the impact of closures of beds in other subsequent communities such as Axminster, particularly in respective of vulnerable older people with complex care needs who would have otherwise been cared for within the community hospital.

These proposals signal a major shift for the majority of Devon community hospitals in their strategic role and function from "hospitals" with a 24 hour service, to outpatient "hubs." The document describes "health and wellbeing

hubs" which could be a network of staff and services. These hubs are described as being designed with and by communities. It is not clear from the document which of the 9 community hospitals that will be losing their 24-hour inpatient service may develop as hubs.

A statement from NEW Devon CCG in July 2015 said that Axminster, Ottery St Mary and would not be closing and it may be helpful to give assurances about other community hospitals affected by this consultation across Eastern Devon.
http://www.newdevonccg.nhs.uk/about-us/latest-news/2015-news-archive--/july-2015/101777

It is noted that the Estates Strategy will be issued subsequently to the consultation (page 32), and this may well give a clearer direction regarding utilisation of community hospitals, and their potential role. It is understood that there are practical limitations to the development of community hospitals as hubs. There are issues of feasibility and sustainability, given the plans to co-located voluntary and community services with limited revenue streams, whilst meeting the expectations of rental income by NHS Property Services. It is noted that there was a previous assurance given by the CCG regarding not closing community hospitals (July 2015).

10. Consultation Process

NHS England issues a guide to engaging local people with regard to the consulting on proposals and plans, including Sustainability and Transformation Plans. The document states that "*STP partners should work with the knowledge, skills and experience of people in their communities, working in co-production to improve access and outcomes. The "Gunning Principles" provide a helpful overview of what constitutes a fair consultation process."* (NHS England 2016).

Previous work by the Health and Wellbeing Scrutiny Committee of Devon County Council, in their very useful review of the Community Hospitals in Devon, concluded that there needed to be co-production of plans for community hospitals.

"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" (Devon County Council 2013).

This was reinforced with work carried out with the support for the NHS Confederation of the future of Tiverton Hospital that concluded *"What seems clear, however, is that involving people early on and being honest about the issues is essential"* (Calkin 2013).

There is a requirement to enable local people to consult on the proposed changes of the consultation proposals. *"Ensure that local people can influence the outcome." (*IRP communication re Torrington). It is difficult to reconcile this requirement with the consultation document that declares that a decision already taken is that community beds will close in Honiton and Okehampton

hospitals. There is nothing on the consultation form that local people are able to complete that relates to their local health and care service in their communities.

A concession was made in the final draft to invite communities to add another option to the four options being put forward. It is questionable as to whether this can be considered an additional option. It is placing a large responsibility on local people to initiate a proposal without having the benefit of being within an NHS organisations with access to expertise and data etc.

One of the Gunning principles is that *"Consultation must take place when the proposal is still at a formative stage – consultation cannot take place on a decision that has already been made."* People living in Honiton and Okehampton may challenge the consultation on this basis, as the consultation describes the closure of beds in their hospitals as a decision already taken. There is no option for them to vote for beds to be retained for their community.

"Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response – those being consulted should be made aware of the basis on which a proposal for consultation has been considered and will be considered thereafter, including any criteria to be applied or factors to be considered." Travel and access were presented as key criteria, and we now know that the information used to guide this discussion was inaccurate.
There is not a "status quo" option, or at the very least a rationale for omitting the option of status quo within the Devon CCG consultation. Within the NHS guidance on consultation, this is required. The lack of a clear appreciation of the current service and its impact on patients and communities means that it is difficult for those being consulted to assess where the service is now, and how this will change in the future. The lack of a baseline assessment makes it difficult to understand or assess the proposed change and its potential impact. This point was also made in the Report on Torrington Hospital which evaluated the test of change for the new model of care (Tucker 2014).

The CHA understands that local people are challenging whether there is an undeclared conflict of interest with regard to the position of the independent Chair, and the CHA understands that this is being taken up elsewhere.

It is assumed that NEW Devon will follow best practice, and have an independent assessment of the consultation responses. The consultation paper offers an opportunity for the public to tick one of 4 options with regard to which of the 3 community hospitals should retain their beds. There is an option to tick a 5th option which the member of the public then describes. It would be helpful to know what will happen if the consultation process results in many different options coming forward that will need to be assessed. In the case of a strong case for an alternative option, how will this be taken forward for further testing. Would the consideration of additional options trigger a further consultation process. Those currently being consulted would not have had an opportunity to give their views on any new options being put forward.

The CHA has received contact from those living in Devon who have some concerns about the scale of change and the impact of the proposals to rural communities. The CHA has also been following social media activity on community hospitals in England, and in particular pertaining to Devon. The CHA maintains a resource network on "community voice" on the CHARM website http://www.communityhospitalsresearch.org.uk/community-voice.html

There would be a case to only withdraw services once the new model of care is established. It may also be prudent to have an incremental approach to the change, using a gateway process at every stage. This would allow for an evaluation of the impact for patients and families and for the local health and care system as a whole. This would also allow time for confidence to be built up in the increased reliance on staff working in community teams visiting people at home.

11. Key Points on Strategic Principles

The proposals are underpinned by six strategic principles:

- Helping people to stay well
- Integrating care
- Personalising support
- Co-ordinating pathways
- Considering patients and families
- Having home as a first choice.

The CHA would make the point that community hospitals help achieve the six strategic principles, and that more account needs to be taken of the impact of community hospital care currently has, and how highly it is valued by patients, carers families and the wider community. The CHA would make the case that it is now the time to increase community capacity to address the needs of older people with complex needs and multi-morbidities. There are serious concerns about the scale of the dismantling of local intermediate care beds across this rural area. It is contrary to research evidence, and also to the needs and preferences of local people.

12. CHA Conclusions and Recommendations

In conclusion, the CHA believes that the proposals in respect of the underlying assumptions, the principles and the option appraisal can be challenged. The CHA is concerned that the proposals have not benefited from being informed by sufficient research evidence and evaluations. The CHA believes that the consultation process does not meet the requirements of the NHS by failing to give a voice and a choice to each of the affected communities. There is no evidence of local planning in a model of co-production.

The CHA suggests that there is a case to be made for agreeing a **"pause"** in the process, whilst further work is carried out for clarification, correcting data and sharing learning from evaluations, research and best practice. In particular the CHA would suggest that there is:

- Local planning with each of the seven communities affected
- A revisiting of the assumptions, options, and option appraisal, with improved accuracy of data including access and finance
- A consideration of alternative options submitted by the public at the invitation of the NEW Devon CCG, which allows time to test, develop and consult on these options
- Further work to share outcomes of evaluations of the impact of community bed closures to date, and to draw from evidence from research on community hospitals and models of care internationally
- A process for designing a gradual and phased implementation plan aligned to the STP timetable with on-going evaluation and a Gateway process

The work identified within these recommendations including working with each community and across the whole health system would suggest a period of no less than six months. There is much at stake for rural communities, and the scale of the adverse response from local people across Devon would suggest a lack of confidence in the consultation, both in terms of content and process. Community hospitals are valued and trusted by local people, with a long tradition of care and with significant support from communities. The CHA would urge the consideration of a pause, to enable further work before final decisions are made.

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