

National Clinical Advisory Team - NCAT

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NCAT Review

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To: North Yorkshire Community Hospitals

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Venue(s): Malton Hospital, Whitby Hospital.

NCAT Visitors: Dr Chris Clough, Mrs Catherine McLaughlin

Introduction:

This report has been commissioned by Janet Probert, Managing Director, NYYCMHS through NHS Yorkshire and the Humber, as a part of the evaluation of the enhanced community pilots in Ryedale and Whitby. The National Clinical Assessment Team (NCAT) undertook a visit to both sites on 7th March 2011. The NCAT review is a key component for evaluating these pilot schemes that were launched in November 2010. NCAT were asked to assess the clinical validity of the model of care currently under pilot;

- Providing enhanced community services seven days per week and through the night
- Single point of contact (SPOC) for access to services within a community setting or within the community hospitals
- Closure of in patient beds in Malton and Whitby

Background to Review

The Ryedale (Malton) and Whitby Enhanced Community Team (ECT) pilots commenced on the 1st November 2010. The key service change was to pilot the closure of one ward in both Whitby and Malton Community Hospitals and the transference of nursing staff (qualified and unqualified) from the wards into the community teams with the aim of supporting patients in their own homes.

The pilot is planned to run for 6 months with an interim evaluation based on four months data in April 2011. A final evaluation based on 6 months data will be submitted to the PCT board in July 2011.

Service delivery model prior to ECT.

Prior to the establishment of the ECT Malton and Whitby had the following composition of services within its community model of care:

- **Community Hospital** – two wards in each community hospital taking a mixture of step up and step down patients with a remit to include 5 palliative care beds
- **Virtual ward team** comprising of District Nurses, HCA's, Occupational therapy (OT) and Physiotherapy (PT) providing between them a model of fast response services, rehabilitation and general district nursing services and case management,

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The community Hospital bed profile was as follows

Community Hospital	Beds	Palliative Care
Malton		
Ryedale ward	19	
Fitzwilliam Ward	22 including 5 palliative care beds	beds used flexibly
In Malton all the beds are covered by the Derwent GP practice to give the medical leadership to admitted patients		
Whitby		
War Memorial ward	20 – 15 GP beds and 5 palliative care beds	Heather Unit – beds used flexibly
Abbey ward	28 – elderly rehab / medicine including stroke and neuro- rehab	
In Whitby the medical cover is a mixed model of two 'medical officers' who give medical leadership to Abbey Ward and GP's who admit and cover their own patients on War Memorial ward including the palliative care patients		

The therapy teams support the community hospitals using an in-reach/ outreach model. This means that rather than having a ward based therapist who then hands off the patient care on discharge, the whole therapy team takes responsibility for supporting patients during their inpatient stay. If the patient is a step up from the community and known to the therapy team, the therapist involved in the community will continue to see that patient during their in patient stay and also follow them out again on discharge. If the patient is not known they will be allocated to the therapist covering the ward and this therapist will retain responsibility for that patient on discharge. The team covers Monday to Friday in hours only.

The District nursing team includes in its remit case management in addition to routine district nursing services. This extended role reflected the enhanced skill set within this team and is based on a commissioned service specification. The working hours of the DN team before the pilot enabled provision of in hours and evening service cover, 7 days per week

In addition to the therapy and DN services in the virtual ward, the community model also included a **Fast Response (FR) team**. The aim of this FR MDT was crisis intervention to prevent an avoidable admission to either acute or community hospital care. Response rates were within 2-4 hours and the team was operational 7 days per week from 8am to 5pm. After 5pm the evening DN service provided a response. This team was composed of OT, PT nursing and generic worker staff and delivered care to a patient for the first 72 hours. After 72 hours, care was handed on to main stream DN and therapy services. The team also facilitated early discharge.

Referrals came to each individual team and often resulted in duplicate referrals for the same patient

Establishment of the ECT.

Following long discussions a decision was made to pilot a change in the model of care delivered in Malton and Whitby localities, moving away from a bed based model and towards a model which maintained patients in their own homes. This change in the model of care resulted in the temporary closure of beds in each of the community Hospitals and a transfer of staff from these bed based units to the community teams.

The community hospitals were re-shaped and one ward on each site was closed. The closed wards were Ryedale Ward at Malton and Abbey Ward at Whitby. This resulted in Fitzwilliam Ward in Malton and War Memorial Ward at Whitby remaining open but with an alteration to the number of bed on each ward

In **Fitzwilliam Ward** in Malton the bed numbers have increased from 22 to 24. Palliative care beds remained on the ward and the medical cover remained with the medical officers

War Memorial Ward (Whitby) has increased its bed numbers to 28. The medical cover is now a mix of GP beds and medical officer beds. The whole bed stock is used flexibly and allocation of beds is based on patient clinical need.

In total 21 beds were closed in Malton and 20 beds in Whitby

The therapy input to each ward remained unchanged with the in reach outreach model on going. For therapy staff this meant increased capacity in the community.

For the nursing staff (qualified and unqualified), some staff were allocated to the remaining ward to cover a mix of vacancies and increased staff numbers to cover additional beds with the remaining staff being transferred to the community team.

In Malton a total of 15.89 wte staff were transferred to the community teams.

The breakdown is:

- 9.37 wte qualified staff (band 5 to band 7) and
- 6.52 wte unqualified staff (band 4- 2)
- 4.12 wte staff transferred to Fitzwilliam ward (0.64 wte qualified and 3.48 wte unqualified)
- Ryedale ward was carrying 4.65 wte vacancies at the point of closure (2.9 wte qualified and 1.72 wte unqualified)

In Whitby 16.30 wte staff were transferred to the community teams. The breakdown is:

- 8.11 wte qualified staff (band 5 to band 7) and
- 8.19 wte unqualified staff (band 4- 2)

13.06 staff transferred to War Memorial Ward (4.4 qualified and 8.66 unqualified). However it should be noted that on War Memorial Ward 3.8 wte band 5 staff nurses volunteered to work in the community so the qualified staff transferred from Abbey Ward was almost a straight swap of capacity.

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In addition to the new capacity in the community, an **Over Night Service** has been established (10 pm to 8 am) and the fast response and district nursing teams have been merged. The merger of the fast response and district nursing teams had been agreed before the ECT pilot decision and it felt sensible with the addition of new community capacity to establish a fully integrated enhanced community team

A single point of contact (SPoC) has also been established as a referral mechanism into the 'new' community model. The aim of SPoC is to give a single point access for referral to all community services including community hospital beds, Enhance Community Team, District Nursing services, Occupational Therapy and Physiotherapy. SPoC is currently being embedded into the referral system for community hospital beds and ECT.

Documents Received:

The following documents were reviewed;

- Healthier Lives 2010-2015
- Community Services Commissioning Strategy 2010-2014
- Enhanced Community Services in Ryedale and Whitby High Level Communications and Engagement Plan
- Patient/Service user Questionnaire
- Evaluation domains for the Ryedale & Whitby pilot of an Enhanced Community Team (ECT)
- Ryedale and Whitby Practice profiles
- Emails from WHAGS
- Letter from Derwent practice

People met:

The program for the visit is attached at Appendix 1 and details who we met during the course of the visit. In addition, we went to see four patients in their own homes who were receiving the Enhanced Community Service. The feedback from patients was very positive with a particular emphasis on the care being delivered within their normal place of residence. For one of the patients, being able to stay at home with his confused wife has meant they can stay together. His hospitalisation would have meant institutionalised care for his wife due to her health needs. The nursing and therapy staff has adapted well to the changes in working practice as result of this pilot and should be commended for their professionalism and willingness to try new ways of working.

The case for change

The changes described earlier in this report, are unquestionably right for patients in this rural part of North Yorkshire, The population should have access to a community service around the clock so patients can choose to have care at home or if the burden of care is too great, then it can be delivered in a hospital. This choice is particularly relevant for palliative and terminal patients who should have the right to die in the place of their choice. The ECT gives patients this choice.

As with many health and social care systems, finance is the key driver for service reconfiguration and this part of North Yorkshire is no different. The pilot of the ECT has been established to give patients choice about venue and mode of care delivery which is in line with community services nationally. Unfortunately the clinical model of care has been completely overshadowed by the requirement to make recurrent

savings within the health budget. The temporary closure of the wards within the two community hospitals has encouraged a culture of mistrust; blame, lack of cooperation and the essence of what is being developed for patients has been lost.

Views expressed:

- Most of the people we met were in favour of the clinical model being piloted; however the loss of beds from both community hospitals has clouded the views of many we spoke to. The SPOC is seen as a positive development and ensures patients are streamed to the most appropriate services.
- The community providers agreed that “the story” about the change has not been told well. General Practitioners do not support the changes, due to the closure of the beds and in their view, a lack of consideration about what these two community hospitals could do to enhance health services for the whole community.
- Patient Groups were deeply concerned that their local hospitals were being down graded and would soon be financially unviable, resulting in closure of the facilities. There was deep concern about health services being stretched to accommodate the work of social services within this proposed model and the lack of reference to social services is an on-going concern.
- Patients who were interviewed as part of this review were all highly complimentary about the service and the support they received from the practitioners within the ECT.

Discussion and Analysis

The model of care within the community that the PT had hoped to introduce (ECT) has much to commend it and the PCT should be congratulated on its farsighted attempt to improve and extend the range of services provided within patients' homes. This is part of a national drive within the QIPP work stream (Quality, Innovation, Productivity and Prevention) to improve quality of care but at the same time reduce costs of the overall patient pathway by preventing admission to or speeding discharge from expensive hospital care. Clearly this is a quality driver we can all support but it must be delivered within the context of overall health services for the community. The PCT, for whatever reason, has lost the support of a number of key stakeholders who have seen the closure of wards (during the scheme pilot) as an attack on the viability of the community hospitals which threatens their long term future. Whilst we received many reassurances from the PCT that this was not the case, they have not articulated a vision for the future of their community hospitals which places them securely within the healthcare system providing high quality safe care which is also sustainable and affordable. A strategic vision for North Yorkshire should respond to the future healthcare needs of the community and how it can be provided in a safe, sustainable way close to patients' homes but within affordable resources.

We view the future of community hospitals in a positive way and can see that they have an important role within local communities in delivering intermediate care (step up and step down), outpatient clinics and other services (in conjunction with secondary care), diagnostics and minor injuries services. They must respond to the health care needs of all the community and not be controlled by any single general

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practitioner practice. Their number and siting will depend ultimately on population size and need, geography, access and affordability.

Community Hospital services are one component of the health care services required by this population, thus it will be important to ensure that appropriate clinical pathways and protocols are in place, agreed with secondary care and other providers, to ensure that the patient is seen and treated in the right place by the right clinicians at the right time. Acute secondary care providers will become more acute, delivering increasingly complex and expensive care necessitating large teams working 24/7. There will be an increasing need for these hospitals to discharge appropriate patients quickly to more lower-cost facilities closer to community resources – this will be the opportunity for community hospitals to reinvent themselves, focusing on the above components of service.

Malton Community Hospital has the foundations of being an excellent intermediate care facility within this health economy. The quality of the real estate, the location and the clinical commitment we encountered, adds to the argument for developing a clear strategic vision for this hospital within the health economy. The local GPs have worked with partners to provide services close to their patients and expressed the view that they want to continue to do this and would like to do more, particularly for treatment of minor injuries, outpatient consultations and minor procedures.

The Fitzwilliam Ward is a pleasant environment with care and attention being taken to respect, dignity and privacy. The case mix of patients is a challenge and does require that the multi disciplinary assessment is led by a consultant in medicine for the elderly. Length of stay is likely to be compromised in a ward that has such a varied case mix and can be improved by consultant input. The nursing numbers on each shift requires monitoring and benchmarking against facilities with a similar case mix.

Whitby Community Hospital is at the heart of its local community. The fabric of the building is dilapidated in places though the clinical areas we visited were of a satisfactory standard. We were concerned that the size and condition of the estate would continue to pose problems of maintenance and affordability into the future.

The clinical teams have worked very hard to adapt to the changes in working practice brought about by the introduction of ECT. The General Practitioners feel very strongly that while the model of the ECT is the right model, introducing it, as a substitute for in patient beds is not sustainable for the future and ignores the discussion that needs to be had about the long term future of the hospital. In Whitby, we found committed clinical teams who want to do the best for their patients. The General Practitioners feel very strongly that the hospital is central to the community and primary and community care provision. As with Malton, the General Practitioners feel they have not been involved in the decision making about the temporary closure of the ward. The group we met would very much welcome an opportunity to be part of the strategic planning of health services for this part of Yorkshire. After all with the introduction of GP commissioning they and their colleagues will have the responsibility for commissioning health services.

The burning issue we were left with following our visits to Malton and Whitby, and discussions with various parties was, “what is the strategic vision for these two facilities and the provision of primary care and community services”? It was not clear to us where the discussions were taking place and how the future of community

hospitals was tied into the commissioning of services for this population. General Practitioners feel strongly that their views are not being reflected in changes to the clinical model. The PCT is attempting to balance the competing priorities of money, clinical effectiveness and outcomes for patients and providers of services, and are trying their best to respond to patients in an environment where there are tensions about the model of care that is being proposed.

Conclusions

1. The clinical model of ECT is a good model of care and every attempt should be made to preserve and develop it. We particularly liked the single point of contact (SPOC)
2. A strategic vision for the two community hospitals needs to be developed. Community Hospitals such as Malton and Whitby can provide intermediate care (including rehabilitation and palliative care), outpatient services, diagnostics and minor injuries. There will be an increasing requirement for this type of service in the future which can be affordable if seen within the context of funding the overall provision of health services
3. General practitioner support for the clinical models is pivotal, but this support has to be grounded in accountability and responsibility for the affordability of the clinical model.
4. The commitment and professionalism of the nursing and therapy teams is commendable and their involvement in shaping services moving forward is pivotal.
5. Engagement with local stakeholders requires further work especially social services so there is a common understanding of the strategic vision for community health services in this part of Yorkshire.
6. Moving to public consultation on the closure of the two wards and the full implementation of ECT is not recommended at this time due to the lack of support from local stakeholders and in particular the General Practitioners.
7. The estate of Whitby Hospital is poor and likely to pose long term problems of maintenance and cost. Future capital planning should proceed quickly from consideration of the strategic direction. Smaller, more modern facilities will more appropriately deliver quality healthcare in a safe, sustainable and affordable way in the future.
8. Strong clinical leadership will be required to lead change within a time of contracting healthcare resources. Difficult decisions will inevitably need to be made about the nature and siting of healthcare services for Malton and Whitby. It is essential that the public is engaged honestly, openly and from the start in these discussions. Much can be achieved but plans will need to be realistic, sustainable and affordable.

Recommendations

1. The PCT considers and acts on the conclusions as above
2. NCAT revisits North Yorkshire's plans as soon as they are developed.

Postscript

We heard that, following our visit and verbal feedback, the PCT had immediately reconsidered their position and put a hold on moving to public consultation. Key actions have emerged. We quote the following from the PCT communiqué to staff at Whitby and Malton

The NCAT team fed back that there is a need to build a vision of a whole system for increased provision of care in the community, including the community hospitals. This will require further shared planning with all stakeholders to identify which services are appropriate for a community hospital setting, as well as a model for 24 hour nursing care in the community. Resources were raised as a concern, including the current provision of qualified night staff in the wards.

We are reviewing this feedback and providing additional information to the NCAT team regarding occupancy levels in the wards. We will also be discussing staffing levels with commissioning colleagues. In the meantime we have reviewed incidents and risks reported and have identified no immediate concerns, but will continue to monitor and risk assess the staffing. There have been times when additional staff has been provided based on dependency levels.