Public Consultation

1 December 2014 – 30 December 2014

Safer Staffing at Axminster and Seaton – Temporary move of inpatient beds

Questions and concerns

29 December 2014

This document details the questions and concerns raised at the consultation meeting held in Axminster Community Hospital on 29 December 2014.
Why is there such an NDHT focus on safety when other areas of the UK run services at 1:10 ratio at night? There has been no directive from NICE or the CQC about Axminster community hospital.

We can only comment on the hospitals that we have responsibility for and in our patch we have made a decision to eradicate lone working on wards.

Your question raises two issues – ratio and lone working. You are correct that there is no nationally mandated ratio for community hospital beds, although several bodies including the Royal College of Nursing think there should be. In options 4 and 5 we do not achieve a ratio of 1:8 although we are working towards it.

Lone working is the issue we are addressing here with this temporary decision.

What made you change your mind? What was the tipping point which made lone working no longer acceptable?

We have been trying to resolve this issue across our services for some time. When you look at risk there are the big things that happen that make you respond immediately, and then there are the smaller, incremental things that build up over time.

The ‘big thing’ that happened was Mid Staffs and the Francis report. Before this report the NHS workforce planners estimated that there was likely to be a national shortage of registered nurses by 21,000 over the next three years. The impact from the Francis report and safer staffing guidance has led to an increase in the number of registered nurses required to care for patients. This shortfall has jumped to an estimated 31,000 registered nurses.

The smaller, incremental things that happened which have compounded the bigger risk are the recruitment difficulties we are experiencing across all our services due to the national nursing shortages and the uncertainty over the future service configuration. Nurses will not be encouraged to move their families from Kent to Devon for a job on a hospital ward that has a question mark hanging over its future. An over-reliance on agency nurses to fill the gaps in the rota causes more risk because these nurses are not familiar with you, our buildings, our services or the Devon health economy pathways and providers.

This wouldn’t have happened if the beds had not reduced in 2013
The beds were brought down because of decreasing patient need and recruitment difficulties – this allowed us to staff a 10-bed inpatient service safely. This was before the Francis report findings and there was no way we could have known how the NHS would be impacted by this report.

The continued uncertainty is very difficult for us to deal with and maintain consistent services. Staff are worried about their jobs. We hope this will be resolved by the CCG quickly.

If the beds close temporarily, we all know they will close permanently. Bed numbers have already reduced from 18 to 10. If beds continue to be reduced incrementally, there will be none.

To address staffing issues and to preserve patient safety, bed numbers were reduced from 18 to 12 in February 2013, and from 12 to 10 in August 2013. While the number of beds has reduced, bed occupancy has remained static at around 85%, largely because more patients are being supported to live independently in their own homes.

The temporary decision we are looking at now is aimed at resolving urgent patient safety issues we are currently facing. As a provider we cannot make a permanent decision to close the inpatient beds. The CCG is responsible for the longer-term future of services and they will make a decision at the end of their consultation. We can assure you that whatever decision we make, it can be reversed.

Why does the CCG keep extending its consultation?

We do not wish to speak on behalf of the CCG but are aware an announcement on the next steps of their consultation will be made in early January.

Why can’t we just wait until you have lost the contract for these services and then the beds won’t need to change?

It doesn’t matter which the provider, they will all have to ensure they have safe staffing on their wards.

Can you confirm you have received the offer of £300,000 from the Axminster League of Friends? This money can be spent in both Axminster and Seaton.

Yes we can confirm we have received this very generous offer and it will be considered by the Board on 7 January.
NDHT is probably the only NHS organisation to make a surplus. Why are you prioritising this surplus over saving Axminster?

All NHS organisations are required to end the year in financial balance and identify a surplus. Last year we had a surplus of £2million and it is recognised that we are a financially sound and clinically high performing organisation. The surplus is how we fund the next year’s capital spending programme, i.e. it is reinvested in local services. Recent community hospitals to benefit from this surplus were Sidmouth and Budleigh where the capital developments were match-funded by the local Leagues of Friends.

So finance is the driving factor here?

No, patient safety is the primary driver to the decision we must take. However, wherever there is a choice of option, it is right that finance is a key consideration along with many other factors.

We are aware you advertise on NHS Jobs, but what else have you done to attract nurses?

NHS Jobs is our most effective method of advertising as this is predominantly where nurses look for jobs. Adverts also appear on other jobs websites like indeed.co.uk and Jobcentre Plus, as well as on Facebook and Twitter. We have attended a number of careers fairs nationally, work closely with Plymouth University to offer student placements and work with local schools to recruit healthcare assistants. We have just supported 10 nurses back to work whose registration had lapsed through our return to practice course with Plymouth University.

We also recruit from overseas and have 17 nurses due to start in February, but this method is proving less and less effective as all NHS Trusts start going overseas to fill their nursing vacancies.

Nationally – following estimates based on the Francis report recommendations - there is a shortage of around 31,000 nurses. There was a 7% reduction in student nurses being trained in previous years, and those coming out of University now tend to prefer to work in bigger cities and centres rather than in community hospitals in rural locations. As there are more vacancies than nurses, people can choose where they want to work. We have lost 6 full-time equivalent nurses at Axminster during the past year, although we have managed to recruit 3.5 full-time equivalent nurses back in that time.
In a letter from Roger French, your Chair, he said this issue cannot be solved by more money or more nurses. What did he mean?

The context of this comment was in comparing the options of the consultation. Our best assessment is that we would really struggle to recruit 11 additional nurses (to fulfil option 3) to resolve the patient safety issues even if we could afford them. We are competing against city hospitals for nurses and we could not have confidence that this would be possible.

In addition, 2 nurses for 10 patients would create a ratio similar to an acute hospital high dependency unit. Over time, given the limited number of patients these nurses would care for (5 at a time) and due to length of stay and complexity of patients there is a risk of nurses deskilling.

Why haven’t you advertised for nurses in the local newspaper, knowing you were in difficulty?

NHS Jobs is where nurses tend to look for jobs. From past experience elsewhere in the Trust, we have found that advertising in the local media hasn’t been effective. However, this is a very valid point and is something we will consider.

We know of a nurse working in Dorset who would love to come and work in Axminster community hospital but says the uncertainty over the future of the hospital has put her off.

This example illustrates exactly the problems providers experience recruiting staff to services when there is long-term uncertainties about the services. We are looking forward to certainty as well.

With military nursing staff being pulled out of Afghanistan, have you done anything to try to attract these?

Yes. We have put a number of adverts in Ministry of Defence publications. The community health and social care team in the Sidmouth, Axminster and Seaton area has recently appointed two nurses who had been in Afghanistan, and who are proving to be highly effective additions to the team.

With all this uncertainty, it’s no surprise you’re not able to attract nurses to work in community hospitals.

You’re right. Once the CCG’s consultation is complete and they have made a permanent decision on where inpatient beds will be located, this will give much more reassurance for prospective nurses and other staff.
If you proceed with transferring the beds to Seaton, what is the proposed date for this to happen?

If the board decides to temporarily move the beds at its meeting on 7 January, the transfer is likely to happen as soon as is operationally possible after the decision.

If the move goes ahead in January and the CCG make their decision around April time, this is a short time. Can't you bring in two registered nurses to get you through this period?

We believe the patient safety concerns around lone working are too great to continue as we are, especially during the winter period when there is greater demand on NHS services and less resilience due to staff sickness, etc.

Also, it is not just two nurses that we would need to eradicate lone working. Ensuring there are two nurses on shift at all times at Seaton and Axminster would require an additional 11 full-time nurses.

However, you are right. When we started this process we were in October and planning for it to be in place by now. The new timescales are another issue that the Board will have to consider on 7 January.

Why did the CQC not visit Axminster or Seaton during the inspection in the summer?

The CQC decides where it visits – not us.

You're working against public concerns. A petition has gained 6,800 signatures. I hope you take this into account.

This is a very difficult situation and we are aware of the strength of feeling among local people. The views of the public will absolutely be considered by the board when they make their decision.

Why are you moving the beds to Seaton and not Axminster? As far as I can see, it's a charitable decision to move them to Seaton as it's not as well used as Axminster. We are being sacrificed to save Seaton as a building.

The main reason for choosing Seaton is because of the acuity (level of illness and dependency) of patients and the fact that the elderly population is significantly higher in Seaton. Seaton's acuity is higher based on national data – not just in terms of hospital patients but the populations of the towns and surrounding villages as a whole.
The figures show that, in the Seaton area, there is more prevalence of conditions like dementia, chronic obstructive pulmonary disease (COPD), heart disease, diabetes and other diseases affecting the elderly. People with these conditions are more likely to need inpatient beds. It wasn’t an easy decision between the two hospitals, so our preferred option is to locate the beds where there is the highest health need.

The over-85 population, which is actually that which we mostly serve, is 58% larger in Seaton than Axminster. This is one of the most significant factors in all of the statistics.

We share your views that hospitals should be as fully used as possible as they are excellent local resources.

Axminster also serves Lyme Regis and other parts of West Dorset. Axminster has a higher population and is far better served with local facilities, including transport. It is a growing town, while Seaton isn’t.

We are aware that Axminster provides a service to some patients registered with GP practices in Dorset. The number of patients from Dorset who use the inpatient beds is minimal. Our decision is a temporary one based on patient safety. The CCG’s consultation will look at the longer-term issues, such as population growth and catchment.

Community hospitals play a very important role locally. The services they provide, particularly for the frail elderly, shouldn’t be restricted to what we do currently. We need to think more broadly about patient need, bearing in mind the increase in population in Axminster, pressures on acute/health services and the economic downturn. Axminster Hospital is a community asset. I suggest it is run as a social enterprise.

These are interesting and valuable suggestions, many of which chime with our and the CCG’s strategies. Our decision is temporary, based on lone working and immediate staffing issues. We would recommend you put forward your suggestion to the CCG as part of their consultation on the longer-term future of services.

How many members of the public can come to the board meeting on 7 January?

The board meeting is a meeting in public rather than a public meeting. Due to space constraints, there is usually only room for 10 members of the public. Two people have already booked a place.
When is the latest we can send questions for the board meeting?

You can send questions up until 9pm on Monday 5 December. This is to ensure there is time for our chairman to consider how to approach them in advance.

Can you offer flexible employment, such as having lower and higher levels of care depending on the patients or using staff from other parts of the hospital?

We already operate flexibility of staffing depending on the needs of patients. It wouldn’t be possible to extract staff from other parts of the hospital as they are busy running clinics, supporting the theatre or providing day treatments.

Who will provide the medical cover for Axminster patients if they go to Seaton? What will happen at weekends?

We understand the Seaton GPs have agreed to look after the Axminster patients on a day-to-day basis, if the beds were to move. The Axminster GPs would still be closely involved in the care of their patients and we understand they have agreed to visit at least once a week. This is still being clarified, including what will happen at weekends. We will update this section as soon as we have more information.

Where is the Equality Impact Assessment for the consultation?

There has been a delay in the equality impact assessment and it is an assessment that has continually evolved as you have told us about the impact you think will be incurred by each option. The final assessment will be included in the consultation outcome document.

Where are the terms of reference for the external review?


Is Health and Wellbeing Scrutiny involved?

Yes. We were unable to secure a meeting with the elected members of the Scrutiny Committee during the consultation. However we are on the agenda of their January meeting where we will be presenting the outcome of the consultation and the Board decision.
Alison Diamond, Chief Executive, has also had an in-depth telephone conversation with Cllr Moulding, the local councillor on the Scrutiny Committee. This is to ensure he was able to participate in the consultation and we confirm we have received his feedback.

**What is the process if someone disagrees with the consultation document you publish?**

It depends on what aspect is disagreed with. As active participants in this consultation you will, hopefully, recognise the description of the consultation and the themes outlined in the document. It is for the Board to consider the information, themes and feedback and make a decision on that basis.

_I think you need to understand the views of the local people. The A&E was closed 7 years ago ‘temporarily’, the beds have reduced from 18 to 10 ‘temporarily’ and neither have come back. There was no consultation on this and so it is not surprising that we don’t believe this latest move will be temporary._

We absolutely acknowledge the strength of this feeling and these decisions – whilst not all made by us – were taken to solve the issues of the day as they presented back then. Today, we give you our whole hearted assurance that if anything is changed it will be put back or reversed if that is what is commissioned by the CCG.

Whatever option is chosen there will be no infrastructure changes which would prevent a return to things as they were or close off any of the longer-term commissioning goals of the CCG.

**You and the CCG are both the same. You’ve both made your minds up.**

We realise the structure of the NHS is confusing but we are very different organisations. The Northern Devon Healthcare Trust is led by Alison Diamond, the accountable officer that will be making this temporary decision.

The NEW Devon CCG is led by a different accountable officer and they make their own decisions.
Why can’t you flip your preferred option so Axminster gets the beds? It has far better facilities and offers lots more services?

There are advantages and disadvantages, risks and impacts to all of the options. The Board is responsible for weighing these all up and making the best decision they can on the information available. The rationale for this decision will be open, transparent and shared – as well as reversible.

There is no silver bullet and we have been struggling with the solution for many months. It is really difficult. The reality is that we have a safety issue and a way that we can temporarily solve it.

Axminster is the more effective hospital so why should the beds move from Axminster to Seaton?

It could be argued that Seaton is more effective. Seaton is coping with a significantly larger, more deprived and more ill population. However, with the same number of beds, they have a better throughput through the hospital and a lower length of stay. Seaton has one of the lowest average length of stay of any hospital in Eastern Devon, despite having a higher acuity of patient; Axminster often the highest. You could make a good case that Seaton has been the most efficient hospital for the past 7 years.