Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Public Consultation

1 December 2014 – 30 December 2014

Safer Staffing at Axminster and Seaton temporary move of inpatient beds

Questions and concerns

8 December 2014

This document details the questions and concerns raised at the consultation meeting held in Axminster Community Hospital on 8 December 2014.

What is a registered nurse?

Registered nurses are professional nurses who are registered with the Nursing and Midwifery Council (NMC) following a three year accredited training programme. To maintain registration with the NMC, individuals must have completed:

- 450 hours of registered practice in the previous three years and
- 35 hours of learning activity (Continuing Professional Development) in the previous three years.

There is currently a national shortage of registered nurses. The Centre for Workforce Intelligence suggest the NHS will be 47,545 nurses short of demand by 2016, so whilst we continue to successfully recruit to most vacancies, there are some hospitals to which it is extremely difficult to attract staff.

What is the difference between an agency and a Trust-employed registered nurse?

Agency nurses are recruited through an agency and are unlikely to be familiar with the hospital, Trust policies and procedures and may have variable experience, compared to Trust-employed registered nurses who are inducted and developed to core values and competences.

What is a community hospital?

A community hospital is local resource usually situated within the centre of a community giving access to a range of services from primary care, inpatient and outpatient services.

The locations of community hospitals in terms of their proximity to a local community and the services they offer can differ vastly from area to area. There are no set services that a community hospital must offer, but services are commissioned based on the needs of their local community.

Inpatient facilities at community hospitals offer medical and rehabilitation services to a very small number of patients (total number of community hospital beds in north and east Devon is 300 compared to the thousands of hospital admissions).

Some patients will be transferred to a community hospital following an inpatient stay in an acute or general hospital, known as a ‘step-down’ service, or on referral by their GP where an inpatient stay in a community hospital is the best place for the health service to meet their needs. This may be when community services are no longer able to keep someone well and supported at home or there is a significant deterioration in the health of a patient.

What is a community health and social care team?

Health and social care teams, sometime referred to as integrated care teams, are responsible for providing support to those in a community setting, whether that is within a home or a clinic. The range of services offered by health and social care teams can differ depending on locality and the needs of the local community. Traditionally services provided will be based on the needs of the patient and can include community nursing services from changing dressing to administering intravenous drugs to support from adult social care, physiotherapy and podiatry.

By reducing the bed numbers over the last three years you have caused the hospital to be unviable

In line with national trends the bed numbers reduced over recent years because admissions to the hospital have been falling over the last three years, indicating a decreasing local requirement for inpatient beds from the local community.

Why is lone working suddenly so unsafe? It has been like this for years.

The guidance and standards have changed since the reports into the care failings at Mid Staffordshire NHS Foundation Trust.

- There have been relatively few incidents relating to lone working, but from investigating the incidents that have happened, it is clear that there are risks from the following scenarios:
- If the senior nurse on duty is called away from her nursing duties to deal with another issue up to 10 patients are left without nursing oversight for that period however short
- The Care Quality Commission (CQC) has formed the view that where there is only one registered nurse they are professionally isolated
- Over time, by seeing too few patients, nurses risk deskilling or losing their competencies through no fault of their own.

We consider these unacceptable risks to patient care.

Is this all about saving money?

Patient safety is the primary driver but we cannot ignore that we must deliver NHS services which are affordable.

Primarily this is because we cannot practically recruit more nurses to the Axminster or Seaton community hospitals.

This option does not provide significant cost savings, apart from avoiding the excessive costs of agency staff. Neither hospital is closing, however it does resolve the patient safety risks in an affordable way.

Why are some of the hospitals so prone to staff sickness?

It is not that our hospital staff are more prone to sickness than others, it is that in the smaller hospitals with a small team of staff, we struggle to fill the gaps in the rota caused when just one member of staff is off work due to sickness.

In these instances, it is usual that we don't get very much notice about staff absences so our managers expend a great deal of effort finding nurses to work to fill the gaps in the rota. We are often on the cusp of not being able to sustain the rota and this is not a sustainable or safe position to continue.

Why do eight patients need one nurse? I thought community hospitals were a stopping off point on their way home from RD&E or Plymouth?

More and more patients are going straight home from acute hospital because of the strength of support in our community teams. The number of admissions to the community hospitals are declining but also those that are admitted have greater acuity and complexity.

Community hospitals offer a very different level and intensity to the care provided in RD&E, Plymouth or Taunton. If you need an acute hospital admission this remains unaffected by the presence of community hospital beds in your nearest town.

How many vacancies have you got in the community hospitals?

Because of the registered nursing shortage we have a large number of unfilled nursing vacancies across Northern and Eastern Devon – averaging at two per hospital.

How many Seaton inpatients are referred to x-ray at Axminster?

April 2013 to March 2014 = 50

April 2014 to end November 2014 = 13

What are the medical costs at Axminster and Seaton

- For 10 bed unit = £50k
- For 18 bed unit = £80k

These numbers are from a model using the average medical costs per bed across the NDHCT community hospitals multiplied by the local bed numbers. Medical costs vary across the region.

What are the premises costs at Axminster and Seaton?

- 10 bed unit Axminster £400k
- 10 bed unit Seaton £300k

Explanation as to why Axminster is 33% higher: The premises costs represent the cleaning, utilities and maintenance costs and are proportionally higher at Axminster. The driver of this difference in cost being the higher floor area at Axminster which is approx. 3400sq meters as compared to 2200 sq meters at Seaton.

What are the capital costs?

- Axminster = £400k
- Seaton = £200k

Explanation for 100% variation: The capital charges and depreciation line breaks down to approximately half capital charges and half depreciation at each site. The reason for the higher costs at Axminster therefore is because of it having a higher valuation than the Seaton site (upon which the trust then pays a 3.5% charge) and a greater level of depreciation as a result of the past capital spend at Axminster by both the Trust investment and the League of Friends contributions.

Please provide the total capital cost for the Axminster Hospital site and for the Seaton Hospital site

Axminster £4.525m, Seaton £2.515m

Please confirm that third party income for beds in Axminster is circa £146k per annum and at Seaton is nil.

No, this is incorrect. Our response is based on the data we have at month 8 of the financial year (up to 30th Nov 2014).

NDHT has invoiced Dorset CCG for £36,515 for Axminster inpatients since 1st April 2014. The majority of those patients were in the first four months of the financial year as in the last four months there has only been one patient from Dorset admitted to Axminster. Based on these fluctuations, forecasting is difficult, however we anticipate that the income we will receive from Dorset inpatients in Axminster Community hospital will range from £36,515 to £54,772 per annum. There has been one Dorset patient that used Seaton hospital in this financial year.

Why aren't we looking at the opportunities for Seaton?

The Northern Devon Healthcare Trust is consulting on a temporary measure to resolve our identified patient safety risks with the current configuration of inpatient services in Axminster and Seaton.

Whilst we have many ideas about the future role of community hospitals and how they will continue to evolve to meet the future healthcare and wellbeing needs of local communities, it is the Clinical Commissioning Group that decides what care is going to be commissioned over longer-term.

Why the short run-up to choose days for consultations in December, a time when people are very busy and usually pre-booked? Related to this, why are meetings held between 2pm and 4pm? Why not evenings/weekends when people are not at work?

We had to run the consultation as quickly as possible as our concerns over safer staffing in the winter period still remain. We also led six weeks of engagement prior to December.

Following feedback, we have set up two extra evening sessions in Axminster and Seaton.

Why are the consultation meetings so limited in numbers? These meetings are not offering the opportunity for fair representation, given that between 700 and 800 people were present at each of the public meetings, the petitions run locally have been signed by 6820 people and the Medical Practice in Axminster alone has over 11,500 patients on the books, plus patients from other practices. You are offering 2% of those affected a chance to consult.

We are not restricting the numbers of people attending. Ten people booked in to attend the first consultation meeting and they naturally fell into two groups of five.

The more people that book in, the more Trust staff will attend.

Smaller meetings are proving to be a good way of holding the meetings as people get the chance to discuss their concerns in more detail and can have a more in-depth conversation with NDHT staff members which is not possible at a large public meeting.

There are also a range of other ways that people can consult – by answering the questions in the consultation document and sending them back via post or email. There is also a form on the website where people can feed back their thoughts:

http://www.northdevonhealth.nhs.uk/consultation/how-to-get-involved/

What is being done about publicising these consultations? There appear to be no posters and you have only made copies of the consultation document available at the Hospital. The fact that the information is available on the internet is useless as the vast majority of people would not look there unless directed to do so. How could they know that the documents are there?

The consultation has been publicised on the trust website and in the local media. Paper copies of the consultation document have been distributed throughout the community. Posters have been put up at the hospitals, GP surgeries, libraries and town halls as well as copies distributed to the community. Adverts have been put in the local press including the Midweek Herald and Pulman's View from Axminster. We have also used Twitter and Facebook to publicise the meetings.

Despite protestations of sorrow in the consultation document of getting it wrong last time, this attempt at consultation would appear even more fragile than the previous one and does not stand up as a public consultation in anyone's understanding.

This consultation is a true consultation and we are acting in good faith to listen to the views of the community and consult with them on the different options available.

There was no previous consultation run by NDHT on this topic, but we are happy to get feedback on how we can improve our processes, which would feed into any future consultations.

The manner in which the options are set out is loaded to say the least. If you want people to make honest representation then you should not be including your preferences, highlighted in bold print. Let people make up their own minds.

It is common practice to set out a preferred option as well as outlining the other options that are available in consultation. We feel it is important that people understand the rationale behind our preferred option of temporarily transferring the beds from Axminster to Seaton.

From the conversations had thus far, people are not experiencing any difficulty expressing their views on the options we have set out.

Axminster and all the other community hospitals should remain in place and plans should be made to increase rather than decrease numbers. These are Community Hospitals and as such a vital part of Care in the Community. It is sad that NDHT seem to believe that Care at Home is the only form of care in the community.

Over the last 10 or so years, the role of community hospitals has changed with a decreasing volume of patients going into them.

We agree with you that community hospitals provide a very important service. However it is crucial that the service offered is safe and resilient. We are consulting because we can no longer offer you a high enough level of service with lone working registered nurses.

The actual safe staffing document is printed in small print making it almost impossible to read. This certainly deters close scrutiny. Why do planned staffing numbers not meet the 'legal safe' levels?

This document contains a lot of information. It is available as a pdf on the website where you can zoom in to view the details.

Our staff are working really hard to maintain safe staffing on the wards. The issues that cause us concern are that our agency use per week is over 20% and we have nurses spending the vast majority of their time without peer professional support.

Post mid Staffs and the Francis report, NHS providers must be assured that their ward staffing is safe. In hospitals of 10 beds with only one nurse, we cannot provide that assurance. The CQC also require us to address this following their recent inspection.

As we have a matron in post whose position covers Axminster, Seaton and Sidmouth Hospitals. Has the federating of other areas been considered? Is there a bank of nurses for cover at these 3 hospitals? As I believe bank nurses are less expensive than agency nurses would it not be the sensible approach to institute our own bank possibly including Honiton and Ottery St Mary in it?

Yes there has been consideration of federation in order to support a peripatetic pool model. This is still being explored and has not been ruled out. From experience where we operate peripatetic pools of staff, recruitment is even more challenging than recruiting to substantive roles due to the nature of such roles.

There is currently cross cover and consideration of staff across localities so no one area is considered in isolation.

Bank nurses are rightly less expensive that agency workers and we do have a staff bank provided through NHS Professionals which is a bank not agency provider. The route is always our first step in temporary staffing and agency is always a last report in terms of escalation. We continue to work with our bank (NHS Professionals) to ensure we have all areas covered but often staff are not available in areas such as Axminster resulting in the escalation to an agency.

An offer is on the table from Axminster League of Friends to finance additional nurses for the next 3 years to the tune of £100,000 pa. Why is this not being considered?

The problem is not financial and cannot be solved by more money. The patient safety risks caused by lone working, staffing shortages and resilience can only be solved by consolidating the beds onto fewer hospital sites.

What about voluntary cover? Offers have been made in Axminster to cover shifts both from RGNs and from HAs. Is anything being done to utilise these people? Have any checks been made on their registration and skill levels?

This offer is being considered and explored with the list of volunteers we have been given.

We cannot use volunteers to provide NHS care; we would have to employ the nurses once we are assured on their registration status, their competency and their availability.

Constant excuse of insufficient funds! As far as I can discover the Trust had an operating surplus of over £2,000,000, in the Financial Year 2013/14. As far as I know the Trust is a non-profit making organisation and therefore this money should be used where most needed – supplying nurses.

Please refer to the previous section – the problem is not financial, it is patient safety and resilience.

Our staff are pleased to be working for an organisation that is not in debt. In their last inspection, the Care Quality Commission recognised the close link between financial health and high quality of patient care. Any surplus is reinvested in developments.

Voluntary Donations are not being considered even when they could ease the situation dramatically.

We are extremely grateful for all the charitable donations that we have received in the past for equipment and resources.

Even if money was able to solve the patient safety issues, we are not permitted to subsidise core NHS care with charitable contributions.

There appears to be no sound costing for additional nursing staff just 'we cannot afford it'. This is not a good enough reason and the question should be 'How can we afford it?'

We have provided the financial breakdown of each option here:
http://www.northdevonhealth.nhs.uk/consultation/supporting-documents/

Attracting 5.5 additional nurses is very difficult in the context of a national nursing shortage and would not deliver value for money given the small number of patients that would benefit from this investment.

There are probably going to be more patients to care for over the next few months with seasonal changes and an ever growing population. Combining patient beds to Seaton with virtually no room for expansion is not a practical option. The RD&E spends most of the time on red alert because patients cannot be moved to Community Hospitals. That is before the peak months of January and February.

The CCG is the body responsible for assessing the local health needs of the population and commissioning the services to meet that need. Whilst NHS providers are often involved in the planning, we can only provide the care that we are commissioned to provide.

At any one time, on average, there is one patient waiting to come out of RD&E to Axminster. The majority of patients waiting to come out of hospital are complex and waiting for packages of care to be in place. Therefore it is not the case that a lack of capacity in Community Hospitals is causing problems for the RD&E.

Axminster is more easily accessed by public transport with many more bus routes than Seaton and a railway stations which Seaton does not have. Axminster Hospital has a bus stop by the gate whereas Seaton is out of the centre with more difficulty in getting there from most areas.

We will feed this comment into our consultation and Equality Impact Assessment as it is commonly expressed feedback. However, it is of more relevance to the commissioners tasked with making the longer-term commissioning plans.

Axminster Hospital has 26 additional services available so that patients needing any of these services do not need to be transported to receive treatments and tests that are required.

Outpatient and day treatment services remain unchanged at Axminster.

Is the hospital unsafe now?

No, the hospital is not unsafe now and so far we have been able to provide cover for the hospital, but the situation is not sustainable and could be unsafe in the future.

How does the nursing staff here feel?

The deputy matrons of both Seaton and Axminster attended the consultation meeting on 8 December and gave compelling accounts of how difficult it sometimes is to maintain safe staffing on the wards.

You are more than welcome to ask them how they feel, however be aware that some will feel there is great uncertainty because the consultation proposes options that will affect their working lives.

Are agency staff truly unknown to the hospital, or do they come back?

Whilst some do come back and we provide longer term contracts when we know we need staff for a few months, many are not known to us before they enter the hospital for their shift.

In addition, we are frequently let down at very short notice by agency nurses who get a better offer elsewhere. Our employed staff do not operate in this way.

Filling 20% of shifts with agency staff puts huge pressure on the matrons and senior nurses and we are responding to the concerns of staff in consulting on actions that will resolve our risks and their pressure.

Why don't we put recruitment ads for nurses in local press?

We advertise jobs on NHS jobs. Nurses know to look there. Nurses do not look for jobs in the local press.

Why don't we plan better for development of nursing staff – e.g. bringing in new nurses? If we were a business we would be planning for future peaks and troughs in workforce

There is a nation-wide nurse training system and we are impacted by the level of nurses in training and how they are deployed to each area. Quite often the supply does not match the demand.

We send our staff to nurse recruitment fairs, support back to work programmes for those who have taken career breaks and lobby the regional bodies hard for our supply of trainee nurses.

Do we need 4 or 5 extra nurses or 11?

The numbers were 5.5 for each hospital, hence the overall figure of 11.

What is a winter crisis?

In winter the demand on NHS services increases significantly. A crisis is when we have insufficient capacity to cope with that demand and we go into escalation by asking our partners for help.

On the 2nd of December this year the NDHT started advertising with the Pulse Agency for RGNs for Axminster Hospital. Why was this not done before if staffing unsafe? Is this the only place advertisements are being placed?

We believe that this refers to an advert placed by the GP practice, not NDHT. All our vacancies are advertised on NHS jobs website which is the place where all NHS staff go to look for jobs

Executives of the Trust are being paid obscene amounts of money in both salaries and benefits. The number of executives seems to be excessive when there is a real shortage of troops. The Chief Exec. is on salary and benefits of £145k , the Medical Director on £115k.

The salaries of Executive Directors at NDHT is commensurate with other NHS Trusts and reflects the degree of experience and level of responsibility of the executive directors.

The ratio of medical staff to administration staff is 1 administrator to every 3.7 medical staff which includes health visitors and midwifery. Very disproportionate numbers (from annual report).

The administrative staff group includes electricians, plumbers, cleaners, porters, accountants, medical secretaries, reception staff and so on. We cannot find the data from the annual report which supports this claim and have requested more information on this.

Patient care and accommodation should come before excessive spending on services like expensive web sites and IT systems. Incidentally the expensive web site is displaying pictures of Axminster Hospital that are 5 years out of date

They do. We are a very lean organisation and have taken steps to reduce the management/ corporate overhead. Every NHS Trust has to have a website and setting aside pages in support of the Axminster consultation did not cost anything.

In Axminster planned hours are lower than actual in all except one case, Night Shift HA which is marginally higher. Therefore one can only assume that the staff are available to increase numbers. The whole of the Eastern Devon Community shows higher actual than planned numbers on day shifts but not night shifts. Northern acute and community hospitals have greater differences.

This question relates to our public reporting of safer staffing on our wards. Our Board reports on safer staffing reflect the rota fill rate but we have only recently had the data to be able to report the amount of agency and temporary staffing being used to achieve this level of care (please see Board reports from November 2014 onwards).

Axminster has been using over 20% of agency, of the 100% of staff in place. This is above our recommended level and acts as a 'red flag' to senior nurses as there are the required number of nurses in place, but they are not from our local team. This impacts on on-going continuity of care and is not sustainable.

This data does not reveal the other risk factors we consider to be significant in Axminster, which are:

- the split shifts staff are working (i.e they work more than one shift a day; or
- the overtime (hours worked in addition to contract)

Both are placing additional and unsustainable demands on the team members at Axminster.

It is reported that there are more sick people in Seaton because there are more care/residential homes. Where a patient is being discharged to a care home, their stay in a Community Hospital bed need be of a shorter duration as carers are already looking after them in the home. When patients are discharged to their own homes, their discharge is not so swift.

From looking at our data on acuity (illness and dependency) of patients, Seaton's is higher than Axminster. Given both hospitals cost roughly the same to run, there was no easy decision between the two, so our preferred option located the beds where there was the highest health need.

We disagree with the premise of your point about discharge because all complex discharges – whether new or existing patients on the community case load – are planned carefully and safely and frequently change according to the changing needs of the patient.

Axminster Hospital provides a service to West Dorset patients and doctors in Lyme Regis do not want patients sent to Seaton. The income derived from these patients will be lost.

The income we receive from Dorset is minimal and decreasing year on year.

Visiting Consultants at Axminster carrying out both patient appointments and minor surgery can be readily consulted should the need arise.

Outpatient and day treatment services remain unchanged at Axminster. Visiting consultants are not involved in inpatient care.

End of life care at Axminster is second to none. The proximity of loved ones is essential at this time. The nearest Hospice is 26 miles away.

We understand how important good end of life care is. The Hospice is very good.

Much of the end of life care provided by our district nurses and the Hospice is provided in the patient's home – at their request.

Can we stop using so many acronyms?

We understand that this is confusing and attempt to avoid acronyms as much as possible. We try to provide glossaries to explain terms that might be unfamiliar.

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Questions and concerns

15 December 2014

This document details the questions and concerns raised at the consultation meeting held in Axminster Community Hospital on 15 December 2014.

What is the current staffing situation at Axminster Hospital?

Over the last 12 months in Axminster we have experienced a 50% turnover of staff. This is primarily due to age profile of the workforce and is something we actively manage across all our services.

Over the last 18-month period through to 30/11/2014, 7 (5.91 WTE) Registered General Nurses (RGN) have left Axminster Community Hospital and 5 (3.87 WTE) have started at the Hospital in that period. 6 (3.38 WTE) Healthcare Assistants (HCA) have left and 5 (3.88 WTE) have started.

At Seaton 3 (3 WTE) RGNs have left during that period and 6 (5.3 WTE) have started.

It is difficult to take a snapshot of 18 months because a number of the RGNs joining us in that period did so towards the beginning of that 18 month period which may account for the larger discrepancy between starters and leavers in that period i.e. a number of the starters may have been replacing staff who left before the start of the reference period etc. 3 (2.6 WTE) HCAs have left and 2 (1.2 WTE) have started in the reference period.

How can we assure the closures are temporary?

We as a provider we cannot make a permanent decision.

If it is temporary what is the end date and when will beds return to Axminster?

The temporary period will be until the CCG makes a decision about its community services provision (current consultation runs until 15th February 2015 and a decision will be made after that) or until current safety issues have been resolved.

Has the decision already been made?

No, a decision will not be made until after the consultation period is over.

How are we advertising for nurses?

We advertise on NHS Jobs. This is where Nurses know to look for jobs. In addition we have run recruitment campaigns across Europe to attract nurses to work with our Trust.

Transport is a big issue – every hour Monday to Friday but limited Saturday service and no service on Sunday

This feedback will form part consultation. We understand that travelling is a big issue for some people and unfortunately wherever we consolidate beds, there will be some additional travelling involved for some people.

Why can't we wait until the outcome of the CCG consultation in February?

We cannot wait when there are patient safety concerns. In winter the demand on NHS services increases significantly. We are currently at a tipping point and do not want enter an unsafe zone with January being such a high risk time.

Why Seaton and not Axminster?

From looking at our data on acuity (illness and dependency) of patients, Seaton's is higher than Axminster. Given both hospitals cost roughly the same to run, there was no easy decision between the two so our preferred option is to locate the beds where there was the highest health need.

You could put 20 beds in Axminster tomorrow and it would be easier as you have the space

A decision is not being made based on where there is space.

Is this decision a hint to the CCG for where you want the services in the future?

No. This is a separate consultation based on the patient safety concerns that we have which has, unfortunately, come about at the same time as the CCG consultation.

15th January has been heard as the planned move is this true?

No. A decision will not be made until after the consultation has closed.

We have heard that beds have been delivered to Seaton this week – is this true?

Yes, they were due replacement beds as the next inpatient service due to upgrade, but this is not related to the possible transfer of beds from Axminster.

Have beds been removed from somewhere in the middle of the night?

Not that we are aware and it would not be standard practice to do so.

Is this just too much health and safety?

No. The safety concerns we have are based upon the level of care we feel we are able to provide at this point in time. With the current staffing levels we do not feel this level of care is safe which is why we are looking at these options.

The timeframes of the consultation aren't fair to the community – posters and documentation only going out in week 2

We had to run the consultation as quickly as possible as we had serious concerns over safer staffing in the winter period. We have tried to distribute documentation as quickly as possible and the consultation has been publicised on the trust website and in the local media. Paper copies of the consultation document have been distributed throughout the community. Posters have been put up at the hospitals, GP surgeries, libraries and town halls as well as copies distributed to the community. Adverts have also been run in the local press. We have also used Twitter and Facebook to publicise the meetings. We thank the members of the community who helped with distributing the consultation document and posters so efficiently to help us.

What will happen with blood transfusions as they need a registered nurse to do them?

We are looking for this service to continue but may be carried out on certain days so will require a degree of flexibility from patients.

Are day service functions going to continue?

Yes, during the temporary closure of the inpatient beds day services would continue to operate from the hospital.

Transport to Charmouth restricts visiting options

We will feed this comment in to our consultation.

Axminster population and catchment areas is growing

The CCG is the body responsible for assessing the local health needs of the population and commissioning the services to meet that need. Whilst NHS providers are often involved in the planning, we can only provide the care that we are commissioned to provide.

In a rural community it is better to have people in hospital where you can keep an eye on them than at home in outlying villages

Our district nursing teams do a fantastic job in providing care to patients in their own homes, even in rural areas, equal to care that one can receive in a hospital. Because of the intangible nature of care provided by our district nurses, people are unaware of the high level/quantity of care received at home.

Will the independent review take into account staffing levels at Seaton as well as Axminster?

Yes, the terms of reference for the independent review include looking at staffing levels at both Seaton Community Hospital and Axminster Community Hospital.

Why are we not taking a long term view?

This is a temporary decision based on the safer staffing issues we are currently facing. The CCG is looking at the longer term planning.

National report says community hospitals have a very important part to play in the future of the NHS

We agree, but this may be as a hub or as a provider of other services not only to provide in-patient beds.

We will provide more answers to questions raised in this session as soon as we have the answers.

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Questions and concerns

22 December 2014

This document details the questions and concerns raised at the consultation meeting held in Axminster Community Hospital on 22 December 2014.

Is this primarily a safety issue?

Yes, we are consulting because we can no longer offer you a high enough level of service with lone working registered nurses.

Why can't we wait until the CCG has made their decision?

The delay in the CCG's long term commissioning decision has left us in a position where we are heading into winter with unsafe staffing levels which are not resilient enough to cope with the added winter pressures put on the NHS.

Where is the evidence that 18 beds would not be needed?

In February 2013 (i.e. with 18 beds) bed occupancy was at 83%. Between February and August there were 12 beds. In August 2013, the beds were reduced to 10 to further ensure safe staffing levels, and bed occupancy remained at 86%. Whilst the number of beds has reduced, bed occupancy has remained static, which supports our assessment that more patients are being supported to live independently in their own homes.

Why can't we solve the staffing levels temporarily until the CCG decision is made?

We feel we cannot continue holding the present safety risks whilst we wait for the outcome of a process over which we have no control. Even if we were to increase the number of agency nurses working on a temporary basis, the safety risks would remain as using over 20% temporary staff is not safe.

Why has the number of beds dwindled over recent years? This has made the hospital less viable.

Across Devon and England, there has been a gradual and incremental reduction in the amount of care the NHS provides in inpatient wards. In Devon we are getting far more successful at delivering care tailored to the individual needs of patients and – for the majority – being able to deliver that care in people's homes, something the CQC recognised in their recent visit.

Axminster is not alone. The reduction in beds in hospitals like Axminster has been caused by a reduction in health care need and our difficulties attracting staff to work in isolated units.

The most significant factor affecting the safety of these units now is the NHS response to the events in Mid Staffs – nurses on wards need to be supported and supervised. This is not possible in hospitals where there is only one nurse on duty at any one time.

There was never a deliberate strategy to make the hospitals unviable.

Unfortunately we are where we are now, and have to look at the current situation, which is not sustainable or safe.

It seems that managers get the pay rises but ordinary staff don't. Nurses put off by low paid jobs.

NHS staff are paid according to national pay scales. In common with the rest of the public sector, no NHS employee has had a pay rise in the last three years (excluding promotions).

What happens if the CCG decides not to close the beds?

Our responsibility is to provide the care that the CCG commissions safely and within budget. If the CCG decides that inpatient beds are needed in Axminster, we will work to re-open the beds in a way that is safe and sustainable.

We agree that the current uncertainty surrounding the hospitals has made it difficult to recruit staff.

Why not carry on as we are?

We believe the current situation is simply not sustainable and would be unsafe in the future especially as we are in the winter period, when demand on the NHS is significantly higher.

The Francis report is focused on acute hospitals and not applicable to community hospitals?

The Francis report was in response to events at Mid Staffs, specifically nursing and medical care on wards. The report is relevant to all care settings.

All NHS providers have to ensure that the care environments have taken on board the recommendation from these reports. Our nurses need support and supervision to ensure they continue to provide high quality and compassionate care.

Transport will be an issue for many patients.

This comment will be fed into our consultation and Equality Impact Assessment as it is commonly expressed feedback. However, it is of more relevance to the commissioners tasked with making the longer-term commissioning plans.

What is meant by temporary?

As a provider, we cannot make a permanent decision to close the in-patient beds and this decision will be made by the CCG at the end of their consultation. The decision we make at our board meeting on 7th January will be temporary until the CCG has made their final decision.

Any decision we make that changes the configuration of service can be reversed.

If we decide to transfer the beds from one hospital to another as an urgent measure to address the safer staffing issues, the decision will be reviewed after 12 weeks but in reality we will not be able to come up with a permanent solution until after the CCG decision. We had no prior knowledge of the proposals in the CCG's consultation and it has been extended once. This delay has forced us to act now as we cannot head in to winter in an unsafe position. Unfortunately this has meant running a consultation at the same time as the CCG.

Who does the CCG report to?

NHS England.

How do we work with the RD&E?

We work in partnership with the RD&E to provide care in many different locations, as well as in patient homes.

Are current vacancies advertised on the NDHT website?

No, all current vacancies are advertised on the NHS jobs website. We also use our Facebook page to advertise vacancies.

What are the staffing levels at both hospitals?

This information is contained in our Board papers – safer staffing.

Losing Axminster to Seaton is a 'charitable' move as Seaton would be left empty and NDHT would lose the building.

This is not the reason why we are proposing the consolidation of beds at Seaton. The reasons behind choosing Seaton relate to the relative health needs of the two populations.

The consultation period ends on the 30th December which is not long enough for people attending the last meeting on 29th to submit their response. Can this be extended?

Following this feedback, we are extending the window for submissions until the 5th January in order to give the people who are only able to attend the meeting on the 29th December time to submit their responses.

Please note that a first iteration of the board papers will be published on the 2nd January, in advance of the board meeting on the 7th. If we receive any significant input between 2nd January and the 5th January, we will amend the board papers accordingly.

Has an offer of £300k been received by the League of Friends? Is this being looked into?

Yes, we can confirm that this generous offer has been received. The board has been made aware of this offer and we are very grateful for it. However, the problem of lone working cannot be solved by more money as there are significant patient safety risks caused when the percentage of temporary/agency staff exceeds 20%. In our opinion, the patient safety risks caused by lone working and staffing shortages can only be solved by consolidating the beds onto fewer hospital sites.

Is there a skeleton staff on at NDDH over Christmas?

While some members of staff will be on holiday over the Christmas period, we will be running as usual. There will be communications staff on hand to monitor emails and take phone calls regarding the consultation.

Why move the beds to Seaton where there are fewer facilities?

Our preferred option has located the beds where we believe there is the higher health need. This has come from looking at our data on acuity (illness and dependency) of patients; Seaton's is higher than Axminster. Given both hospitals cost roughly the same to run, there was no easy decision between the two.

Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Public Consultation

1 December 2014 – 30 December 2014

Safer Staffing at Axminster and Seaton temporary move of inpatient beds

Questions and concerns

22 December 2014

This document details the questions and concerns raised at the consultation meeting held in Seaton Community Hospital on 22 December 2014.

Is the aim to operate at a nurse/patient ratio of 1:8?

Yes, this is the recommended ratio to which the Northern Devon Healthcare Trust has committed to working towards. We understand Somerset has just opted for a ratio of 1:7.

Are we going to lose 2 beds with your proposal?

Yes, but we will be investing in more community nurses and therapists in Axminster to provide more care to people at home. This will mitigate the loss of these two beds.

Where is the evidence that 18 beds would not be needed?

In February 2013 (i.e. with 18 beds) bed occupancy was at 83%. Between February and August there were 12 beds. In August 2013, the beds were reduced to 10 to further ensure safe staffing levels, and bed occupancy remained at 86%. Whilst the number of beds has reduced, bed occupancy has remained static, which supports our assessment that more patients are being supported to live independently in their own homes.

Can we add another option – 16 beds in each hospital?

The Trust cannot consult widely with the community on other options at this late stage. However, all other suggestions received during the consultation process will be considered by the board.

Lone staffing is not a new issue, why the rush to implement this temporary solution? Is it justified if the CQC didn't raise any red flags?

The situation is getting progressively less safe all the time. In winter the demand on NHS services increases significantly. We are currently at a tipping point and do not want enter an unsafe zone with January being such a high risk time.

The CQC did raise issues around lone working at our community hospitals in its recent inspection report (covering the whole Trust) and we are required to address their concerns within a reasonable timescale.

Which agencies do we use?

We always try asking existing staff as a first resort and then go to the NHS Professionals bank. If they are not able to fill the shift then we go to agencies such as Plan B, Ark Nursing, Arrows Group and Newcross. If they are not able to find a nurse, we go to Altius and then finally to Thornbury, who are the most expensive.

Is it lack of investment that has led to this situation?

The reduction in beds was primarily caused by staffing issues (see above) and a desire to increase the nurse to patient ratio. It was never a strategy to reduce the number of beds in order to save money or make the hospitals unviable. Unfortunately we are where we are now, and have to look at the current situation, which is not sustainable.

Is it cheaper to provide nursing in a community or acute hospital?

The average cost of a 24 hour stay at an acute hospital is £150 (exclusing Intensive Care Units which are closer to £500 given the 1:1 nursing care). The average cost of a 24 hour stay in a community hospital ranges from £250 to £400 depending on the size of hospital (smaller hospitals are more expensive).

Have you ever seen a hospital that has closed and then reopened?

Yes, Stratton Hospital closed for over a year for a complete refurbishment and then reopened.

Can Dorchester patients come to Axminster Hospital?

Yes. We receive patients from many acute hospitals. There are no clinical or operational reasons why patients cannot transfer into a community hospital of their choice if we have space and the correct admission documentation.

Are we working with the CCG on this? Can we ask them to make their decision sooner?

Yes, we are working with the CCG and have asked them to contribute to the consultation. The CCG is consulting separately over the long term provision of community services. They are aware of the operational difficulties caused by uncertainties for our staff.

Have we looked at technological improvements that could help support lone-working nurses – e.g. Skype?

Yes, we already deploy technology solutions and tele-medicine to assist our clinicians caring for patients.

However, technology will not solve lone working because there will still be a single nurse working for long periods of time without supervision or support. Technology also does not address the risks when an agency nurse who does not know the hospital, systems or patients, hands over to another agency nurse who also does not know the hospital, systems or patients.

Are there the same issues for acute beds?

Not in terms of lone working. In acute hospitals the nurses know that there are other nurses and doctors working in the same building that can be called upon for help, advise and support. This is not the same for community hospitals which are isolated and without the possibility of instant physical support should it be required.

Despite our best endeavours, all hospitals can experience staffing difficulties from time to time. At North Devon District Hospital we sometimes have to close bays on wards due to lack of staff. However, in a large hospital you can move staff around more easily to fill gaps. You cannot do this in the community hospitals when there is just one registered nurse on duty.

What have we done to try and recruit more nurses?

Please see our responses on the message boards for more information. http://www.northdevonhealth.nhs.uk/2014/10/drop-in-sessions-at-axminster-hospital/#comment-71320

We do generic advertising on the NHS Jobs website and it has proved very successful at attracting new recruits. These adverts are done on a monthly basis for the eastern locality and the adverts cover all our community hospitals. We have used a number of recruitment methods over the years and have found this to be the most effective. It is unfortunate that the uncertainty over Axminster and Seaton's future makes it more difficult for us to recruit staff.

Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

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?

There are now published on our website following a short delay. Visit the Supporting Documents page on the Consultation website: http://www.northdevonhealth.nhs.uk/new/wp-content/uploads/2014/12/TORexternalassessmentAxCommHosps2014finalversion.pdf

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.