Barnstaple 7 September 2015

Questions and concerns

Decision-making criteria

Why are we reducing beds when we have an ageing population?

The population of Barnstaple has grown significantly. Does the number of beds reflect the changing demographics?

Devon County Council (DCC) and the Clinical Commissioning Group (CCG) look at demographic changes when planning health and social care services.

Modernising clinical practices and the increasing use of technology in healthcare means that we will continue to need far fewer beds for an increasing population. The CCG is responsible for planning and commissioning services that meet long-term health needs. They have determined – through a modelling exercise - that the number of community beds needed across Northern Devon is approx. 40.

What if you don't have a car? Many people find using public transport very difficult.
Whilst Devon has very high car ownership rates we know that this is an issue for many people. For this reason, it is one of the consultation decision-making criteria so please give feedback on this when making your comments.

What about the quality of the building stock? North Devon District Hospital is getting old.
Again, this is one of the decision-making criteria we will take into account when the Board reviews the outcome of the consultation. North Devon District Hospital (NDDH) was built in the 1970s, South Molton and Holsworthy are relatively new.

We have a planned scheme of renovations at NDDH so we are constantly modernising the building, regardless of what the outside looks like.

Do we get an increase in demand at holiday time? And how do we afford this?
Yes, there is an increase in demand during the holiday period – both summer and winter. At NDDH we get paid by activity and for the activity we do, so the more people we treat, the more money we get. There tend to be fewer inpatient admissions in the summer.

In terms of tourists, we establish their home county from their postcode and invoice the county's health authority to ensure we get paid for the treatment Devon provided.

Workforce

How can it be more cost-effective to provide nurses in the community rather than in the hospital? Wouldn't you need to recruit more nurses? We thought you had a problem recruiting nurses.
This is a question we are often asked and can assure you that it is more cost effective to deliver community services in people's home because we can spend longer and see more patients than a hospital would.

We already have community teams in place across North and East Devon that are supporting 7000 people in their own homes at any one time.

Replacing community hospital beds with enhanced community services will only add a small number of additional patients to the 7000-strong case load. We will redeploy nurses from the community hospitals into the community so we know we will have the nurses we need to provide this care.

Home-based care

Can you provide an example of a typical care package?
It is very difficult to do this as people have very different needs. People have nursing needs, rehab needs, physio needs and care needs. All of these are offered through a package of care that is designed around the individual needs of the patient. This could involve night-sitting if someone needs help throughout the night. These care packages are for a short period of time, to replace the care that someone would have had whilst in a community hospital.

Would you make these changes if your funding had not been reduced? What evidence do you have that this is a better model of care?
Whilst the finances are clearly a real issue for us, we would not be going down this route if we did not honestly believe that this model would provide better care for patients.

The National Audit of Intermediate Care Report shows that costs of this care is a third of that provided in hospital bed and the outcomes are the same.

The Kings Fund is a well-respected national body that has produced evidence on home-based care here

Locally, we have data from several towns where inpatient beds have been removed and we have not seen an adverse impact. For example, in Torrington and Ilfracombe we see an average of only 2 admissions per month from each town to another community hospital. A&E admissions from people in these towns are in line with rest of Devon and we receive feedback through our Friends and Family Test that there is high satisfaction from patients receiving care in own home.

In addition, there is evidence that our community teams are identifying and supporting patients earlier when their health is deteriorating, which is reducing unplanned admissions to NDDH.

But people feel safer in a community hospital bed.
When people really need to be looked after, there will be a bed for them.

However, being in hospital is not the safest option and we need to debunk that myth. Long stays in hospital beds cause increased risks of muscle wasting, and a reduction in cardio-vascular capability. There is also an increased risk of infection, pressure damage and falls for people who stay in hospital for more than 11 days.

People who stay at home have better levels of independence. We know that about 40% of people who enter a community hospital will end up going into a care home, as their independence has deteriorated so much. We know that people would much rather live at home than in a care home.

What we are talking about is an exchange. We are talking about exchanging 21-26 days in hospital for care at home. We are replacing these beds with enhanced community services.

For example, in Barnstaple, where we do not have a community hospital, we have a 'Pathfinder team' in the acute hospital. This team pulls patients out of hospital and supports them leaving hospital and back to their home. Not everyone needs to be in a community bed. The evidence suggests that we are successful in supporting people in their own homes, reducing the risk of harm and getting them home so that they can benefit from rehab support, physio etc.

Are those services in place?
Yes, this happens already. We already have the teams in place who are currently looking after 6000-7000 people in their own homes. The extra number of people coming from a community hospital until is small in comparison.

Do you take into account the support/care that people have at home? How far do you go in determining whether the home environment is suitable?
People are assessed before they go home and the availability of family, friends and support is taken into account. We also take into account the patient's wishes and their capacity to make the decision.

How often do you have to use private nursing homes and how much does it cost? Devon has just closed its care homes.
We are talking about the replacement care that NDHT provides for someone who would have otherwise been in a community hospital bed. The Trust provides community nursing, physiotherapy and occupational therapy, plus short term, health-funded social care. Devon County Council is the body that

covers longer term care in private nursing homes so this is out of the scope of this consultation.

Option of community beds at NDDH

Isn't NDDH always busy – how could you fit in more beds?
We are seriously looking at this but we working through the detail of how we could fit all the beds in. We included this option as our clinicians thought that the improvements we were currently making at NDDH would mean we could consider offering community beds at NDDH.

Last winter was really difficult across the country and in February we started our planning for the next winter to ensure that we learnt from our experiences. We brought in a national team to help our staff put in place an action plan which is already working really well. We monitor patient 'flow' through our hospital and the upshot of all of this work is that we're freeing up capacity at NDDH which has led the teams to consider the frailty unit at NDDH. We need to look at whether the beds that will be freed up by this process will be sufficient.

We will pursue our plans for frailty assessments, regardless of the outcome of this consultation because when people turn up in hospital, getting a rapid assessment of their health need is really important and will mean they get the right care in the right place.

Will putting all the beds at NDDH be putting all your eggs in one basket and therefore more risk? No flexibility for surge and high infection risk
We have contingency plans that cover all these sorts of examples of major pressure on our services.

However, this is a very valid point and one that would need to be considered carefully by the Board when making their final decision. While there are positives of having all services under one roof, there are of course drawbacks and an increased infection control risk could be one of them.

Consultation process

What is the relationship between you and the CCG and why are the two consultations separate?
We have a very good relationship with the CCG but naturally there are tensions across the health economy due to the financial position of Devon.

We hoped to be able to combine the CCG's care closer to home consultation and the service change we were being required to do as a result of our 2015/16 contract settlement.

In August it became clear that our timeframe could not be aligned to the CCG's and we respect the CCG's decision to separate Care Closer to Home.

Why is this happening before winter?
We feel that it is important to make a decision about the future configuration of community services before the busy winter period. We believe that looking after more people in their own homes reduces the likelihood of unplanned hospital admissions and would therefore be of benefit to get this up and running before winter.

The finances

Are there two different budgets: NDHT's and the CCGs?
Yes. CCG get an allocation for their area from the government to buy the services from providers like hospitals, the ambulance service etc. We negotiate a contract with the CCG every year and that is the amount of money we have to spend on delivering these services. In the acute hospital, we are paid on an activity basis – e.g. we get a sum of money for each hip replacement we carry out. For community services, we have a block contract, which means we are allocated a set amount of money to deliver all community services.

Do you get any money from DCC?
We work jointly with the DCC but we do not get paid by them. There are some jointly-funded posts for people who work for both the NHS and for DCC to improve the integration between health and social care. But we do not get a sum of money from DCC to deliver our community services.

The only slight variation from this is our recent move into providing domiciliary care. We are therefore paid for these 300 hours of domiciliary care per week that we provide directly.

What is the budget?
NEW Devon CCG's budget is £1.2 billion
Our budget is around £230 million
In order for us to deliver our financial plan, which includes £2.3M surplus we have to make £11M of savings.

Why do you need to have a surplus? What do you spend the surplus on?
Every NHS organisation is required to make a surplus. This enables us to have an investment fund for next year to spend on infrastructure, IT equipment and building works.

If we do not make a surplus or balance our books we will make Devon's financial position worse and there is central pressure on us to be successful in delivering safe and effective care within our budget.

How much will you save by closing a hospital? Have you done a proper financial assessment of the different options?
For each inpatient unit we take out, we make a net saving of approximately. £700K. The savings are broadly the same for each hospital as we replace the beds with approximately the same amount of money per bed to reinvest into community services.

However, please be aware that we are not talking about closing hospitals. The hospital will remain and continue to offer many really useful outpatient services. The plan is to develop these centres into Health & Wellbeing Hubs, based on the requirements of the local area.

Why are you being asked to make such stringent cuts?
All public services have to make efficiency savings every single year. The health service in Devon is particularly financially-challenged.

What about wastage? How do you ensure that there is no wastage in the system?
All departments across the Trust are charged with making efficiencies. We target procurement with savings targets as well. We are continually looking at this issue and we benchmark ourselves against other organisations and year on year. There is a national initiative looking at best value procurement across the NHS which we very much support.

Missed appointments are a waste of time and money. We have implemented systems where patients receive text or phone messages reminding them of their appointments.

Salary is a very high proportion of cost. How can you compare the wastage of time?
The biggest inefficiency in our system is use of agency staff – last year, this cost us £11million. We have revamped our way of recruiting people, locally and from overseas. We are also looking at how to retain staff, and encourage them back to work. We are also working with Petroc to train younger people and give them a career in healthcare, working up from an apprentice.

We collecting a great deal of data on how much time our nurses spend on visits, patient facing time, time travelling etc. We use this data to ensure that our community teams are as efficient as possible.