# Bideford Thursday 27 August, 2015

## Questions and concerns

## Decision-making criteria

**The government has stipulated that Bideford has to have 4,000 new houses built but there seems to be no structure for extra doctors or hospitals. If you close community beds then the system won't be able to cope. Beds will be blocked as there will be nowhere to send people.**
We know there will be an increasing and ageing population. The Clinical Commissioning Group (CCG) and Devon County Council (DCC) look at the demographic make-up of the population and plan services accordingly.

The CCG carried out a bed-modelling process which took into account demographic changes. It concluded that we needed approx. 40 community inpatient beds in North Devon and Torridge.

People tell us they want to avoid being in an institution if possible. They want to maintain their independence as long as possible. We don't equate a growing population with more beds as that model of care is unaffordable.

This is because we can care for more people if we look after them at home. On average, it costs around £75,000 a month to staff a community hospital for nursing. In a month, a 16-bed community hospital looks after about 21 people. For the same amount of money, we can deliver the same level of care to approx. 82 people in their own homes.

**But new homes mean extra council tax. Can health services not get some of this money?**
I'm afraid we can't answer that question as unfortunately we cannot access the income from council taxes. However, about 15 months ago, the government created the Better Care Fund. At the moment the budgets are very separate but, moving forward, the Better Care Fund will enable health and social care to be more closely integrated.

**When you get a surge in community hospital beds, where will you get the staff to cope? They can't be pulled back again if they've moved into the community.**
Surge is an important issue and we will be looking at which hospitals can cope with periods of surge as part of this consultation. Some hospitals are more amenable to an increase in beds based on their size and shape. We have escalation plans in place when this happens.

In East Devon, last winter, the resilience funding was invested into both the rapid response service and we increased the community hospital beds by 16. We found that the investment in rapid response was a much better use of the funds as we can support a lot more people in the community.

**This is all about money. North Devon has a lower life expectancy rate, particularly in rural rather than urban areas. I've been told there is a formula according to wages and so Devon gets 11% less than elsewhere. Cuts in police, education are also penalising rural areas.**
We are not responsible for setting the budgets or funding formulas. If you are not happy with the government cuts then perhaps you should be lobbying your MP about this. However, deprivation and inequality are criteria which will be considered when the Board makes its decision, so please feed this into our consultation.

## Home-based care

**Our care homes are closing, there won't be enough space. I have had several friends with elderly parents. The care homes are full.**
In this consultation we are talking about the short-term health-funded care that replaces a stay in a community hospital. We are not consulting on the long term social care (or domiciliary care) that is delivered by social services and which is means tested.

Our complex care teams consist of community nurses, therapists and social workers who are supported by a coordinator. The Rapid Response service provides visits during the day and overnight sits for up to a week, so providing care over a 24 hour period.

We do sometimes place people in nursing and residential homes for a short term period, so that therapists can come in for rehabilitation. We may purchase a nursing home place for a short term, to enable someone to come out of hospital, and this is health funded.

**What are you doing about the community nursing service? As a GP, I can see they are stretched and can't take on any more work. There don't seem to be any new recruits.**
Based on our past experiences in Ilfracombe and Torrington, we feel confident that we will have sufficient nurses, therapists and healthcare assistants to deliver the short-term, health-funded care that replaces a community hospital stay. We would not even consider removing community hospital beds unless we were sure that the alternative was safe and effective.

There are challenges in community nursing, but it's a lot easier to recruit to these teams than to hospitals. People like the multi-disciplinary work and development opportunities.

**As a retired district nurse, I know that unless you have the right people in the right place, it won't work. It's a whole different ball game switching staff from hospitals into the community. Do you have plans to train them?**
We will consult with the nurses at the community hospitals where the beds close; their skills and work preferences will be considered and they will be found alternative positions, either in the community, or at the acute hospital.

We would make sure they have the skills and support to help them transfer to working in the community and we have found that the staff who were moved from the hospital to community nursing in Torrington and Ilfracombe are very happy in their new positions.

**I've recently come out of NDDH. It was fantastic. There were three elderly ladies who had walking problems and needed support. They went to Bideford for two or three weeks and had a smashing time. They couldn't have been sent home because they all lived alone and wouldn't have had the strength or confidence to walk at home. They needed the support available at Bideford.**
Some people do need to have support in the early phases of their recovery and we are not suggesting that everyone would be treated at home. There will always be some people who have to be treated in a community hospital. We work closely to plan the patient's discharge home or to another setting for rehabilitation.

**Care closer to home doesn't work. There are not enough community nurses or carers. We shouldn't shut any beds until it's sorted (story read out of 83 year old lady).**
I'm afraid we can't get it right every time and we are truly sorry when things go wrong. However, we do believe that for many people, being cared for at home is safer than being in hospital.

**Ten years ago, there were excellent community rehab teams that supported discharge from NDDH. These teams have been dismissed. There is a lack of care homes locally and nowhere for patients to be safely discharged to.**

**Care homes are businesses. Many are care homes rather than nursing homes. There are 116 beds for the 39,000 population. All the care home beds are full or have been closed. They are all privately run and are there to make money. They don't want empty beds.**
We have heard people's concerns about access to social care in the local area. Care home beds are accessed through a system run by DCC. However, we need to make the distinction between the social care that we're talking about in this consultation, and the longer-term care which is what you are referring to.

As a Trust, we support people with reablement and social care for a short period of time to either prevent them going into hospital, or help them when they are discharged. This is free and where people go depends on an assessment. Our multi-disciplinary teams sometimes use nursing or residential homes when appropriate for 1-2 weeks and therapists would go into the home and rehabilitate the patient. This is a short term placement for people before they go home. Long-term social care is not part of this consultation.

**How do people get access to a care home bed?**
Care home beds are accessed through a system called brokerage. Beds do come up in nursing homes on a rolling basis but sometimes we do have to put people out of area.

We have a care home support team which is a team of community nurses who work with care homes to provide ongoing support for people working in care homes to help them improve their services and address the most frequent causes of hospital admission. This service has won awards and is being rolled out in East Devon.

**What does advanced community care mean to a patient and who leads this?**
In places such as Torrington, Crediton, Moretonhampstead and Ilfracombe, where inpatient beds have been removed, we have invested in additional community services. This means

that patients have access to community services or support – nursing, therapy or social care – over a short period of time. The community team leads this – a matron or nurse or physiotherapist, working in conjunction with a GP.

**A friend died recently at home. The hospital had organised community care but the nurse didn't come for three days. I rang up four times to complain. There are flaws in your community package and elsewhere.**
We are sorry if this is the case. Unfortunately there are no perfect systems and we would like to speak to you individually to find out the details and follow this up. Where care doesn't go as well as it should, we feed back to the teams and improve our services. Having said that, the CQC has inspected and found our services were good. In fact the inspectors said that they wished they lived in Devon, so good were the community services.

**We have to look at the resilience of the community services.**
We agree that the resilience of the nursing teams is an important issue. We understand the pressure on nursing teams as there's a national shortage. To address this, 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. Plus we are working with Petroc to train younger people and give them a career in healthcare, working up from an apprentice.

However, the easiest place to recruit to is community nursing teams. It is much harder to recruit staff to work in community hospitals.

**You said most patients are in favour of being treated at home, but many would rather be in hospital.**
Many people do say that they would rather be looked after in their own home, but we recognise that this is not for everyone. A multi-disciplinary team, including their GP will assess them as to where the best place for their treatment should be. It is a combined decision, with the patient involved.

**If we lose some or all the community hospital units, people will be pushed out of the acute hospital prematurely.**
Ilfracombe has been closed since last November. The results are clear that outcomes are at least as good as when the inpatient beds were open. The length of stay has increased by two days for patients who have had to go to NDDH rather than a community hospital.
We have significantly reduced community hospital admissions and people are being treated at home successfully. We are constantly looking at how we can help these patients stay at home and keep their independence.

**What community support will be in place where beds go?**
Because all community services vary, we will invest in services according to local need. We will increase the numbers of community nurses, therapists, rapid response care, including overnight care. The level of community enhancement will depend on where and number of beds and what exists already.

**Who will be responsible for coordinating the care package?**
The coordinator is in the community care team and would be the most appropriate person from that team, either a community nurse, social worker, therapist or community matron.

**One of our big problems is getting the long term packages of care.**
We have heard concerns about this and have started to deliver domiciliary care ourselves, as a health-led domiciliary care provider.

**There is a lack of cooperation between social services and health services. Day care services are closing, care homes are closing, community beds are closing.**
We recognise that joint working between health and social care is vitally important. One of the benefits of our teams is that the staff are jointly funded by health and social care, so, on a day to day basis there is close joint working in our community teams. We work together with social workers and community nurses at an operational level. At the strategic level, DCC and the CCG are working together. The One Ilfracombe project is a good example of agencies working together.

**How can you look after people in same way at home? What if someone needs 24 hour care?**
If the patient needs the security of 24 hour care, then they should have it. The assessment will show whether patient needs this level of care, but we do offer round the clock care when appropriate. Again, we must reiterate that if a person needs to be in a community hospital then they will be given a place.

**What is the maximim number of patients a community nurse can visit in a day? If there are many patients, do the nurses just have to visit more and more patients?**
This will depend on the nursing needs of the patients. Our community nursing day teams, including rehabilitation nurses, undertake predominately planned visits with a relative small number of referrals for unplanned visits on the day. We have an urgent care team that undertake mainly unplanned visits with referrals made that need nursing intervention on the day.

Not all patients require daily visits. The number of visits depends on the complexity of the nursing intervention required, the skill of the nurse and the area covered. As people progress, their different nursing needs are assessed. The planned visits are collated on our electronic systems and the different teams talk to each other to review the visits required. We have to run safe services and our teams know what is safe and reasonable, even though we don't have a maximum amount of visits. Each visit could last anything between 30 min to in excess of an hour, if this is required by the patient.

The nurse-patient ratios of 1:8 do not apply in the community but we have to offer safe services. We monitor the length of time community nurses spend with patients and we have found that the amount of time they spend, face to face, with a patient is increasing. We look at patterns and averages to understand demand.

**Do you offer a 24 hour service?**
The Rapid response service provides care over a 24 hour period including care visits during the day and overnight sits.

## Community beds at NDDH

**How does NDDH have spare capacity? How many beds would be free?**
At this moment, we don't know if NDDH has extra capacity. It's an idea we are working up and at this point we can't discount it. This option was put forward by the operations teams at NDHT and so we are considering it as we would consider any other option put forward during the consultation.

We monitor patient 'flow' through our acute hospital and have been carrying out work to improve this. The number of beds is dependent on the number of patients and how long they stay in hospital. With routine surgery, where the average length of stay is lower, we don't need so many beds. In medicine, we case-manage people staying for two weeks or longer to make sure they are in the right place.

National statistics show that if a patient stays in a hospital for over 11 days, their risk of a complication is increased, so as well as freeing up the beds, we are improving the outcomes for patients.

**How would the frailty service be formed and who would run it? I'm a GP in Bideford. There's a GP crisis in Britain – we need 5,000 in the next few years – and we are worried that this will end up back on our laps.**
There is a team that looks at the resilience of the entire health system and our ability to cope in the winter. 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.

When a frail elderly person comes into hospital we will carry out an assessment of them and immediately start planning their pathway through the health system and their discharge out of hospital. We already have an excellent Pathfinder team and we will use care of the elderly resources available in an innovative way.

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.

**How would it work if there was a "community" ward in NDDH and the hospital was suffering a period of extra demand, for example in winter? Would the "community" beds be taken over by the acute patients?**

This is something we are currently working through and we agree that the NDDH option would have to provide the opportunity to flex up our capacity to cope with winter pressures. There is a possibility that, at periods of surge, someone requiring acute treatment might have to be placed on the community ward temporarily. However, I am sure that you would agree that if there was someone urgently needing hospital admission, then using an empty bed in the community ward would be preferable to turning them away.

## Consultation process

**How are you adhering to the 4 tests of change when the CCG has no confidence in your process?**

- Clinical evidence: there is both national and local evidence from towns where inpatient beds have been removed that care is as good, if not better than before.
- Support from commissioners: we have written support from the CCG to consult on how we can deliver safe and effective care within the budget. They have separated their Care Closer to Home consultation, but this does invalidate NDHT's consultation.
- Patient choice: Patient choice refers to the choice of provider as set out in the NHS Constitution. It does not infer that patients have a right to choose whether they are admitted to a hospital or not. When you are in our care, clinicians will work with patients and their families to design a care plan that meets your needs and preferences where that is possible.
- Robust engagement: our consultation process follows guidance from the Cabinet Office. Hundreds of people have attended our consultation events and we have received hundreds of feedback forms and letters. People have been given various ways to feedback their views and we feel that we have followed a very robust engagement process.

**Why have there been so many changes? I was a stakeholder group when we were told that Ilfracombe was out; now it is back in. NDDH wasn't an option then, now it is. Where will we be by the end of September?**
We initially felt that Ilfracombe was not an option as it could not accommodate 16 beds without significant refurbishment which would be costly and time-consuming. However, we listened to the Ilfracombe stakeholders who said that they wanted it back in as an option. If someone wants to suggest another option it will be explored. That is why we added NDDH – we were responding to feedback from our operational team.

**When will the decision be made?**
A decision will be made by the Trust Board on the 6 October and the changes will be implemented before the winter, as soon as it is safe to do so.

**We feel that you have already made the decision! Is this just a tick-box exercise?**
We have not already made a decision. However, it is true that the overall number of beds will reduce. The decision will be made on the 6th October and we need your local knowledge and input to help the Trust Board make its decision.

## The finances

**I've heard that it is five times more expensive to treat people at home. How can this be saving money?**
That is not true. It is actually more cost-effective for us to treat people at home. By moving to more home-based care, we can look after many more people for less money: a 16-bedded community hospital unit costs approx. £75K per month for nursing. In one month, a

unit like this cares for around 21 people in a month. For the same amount of money, we can care for around 82 people per month in their own homes.
For each inpatient unit we take out, we make a net saving of approximately. £700K. The savings are broadly the same as we replace the beds with the same amount of money per bed to reinvest into community services.

**This is austerity. Why are we not looking to increase the buildings and hospitals? Why are you not making a case to ask for more money?**
We do fight for every penny but we have to live within the money available. The NHS nationally is charged with being more efficient. We do challenge our financial allocation and went to arbitration with the CCG to fight for our budget. However, we now have to operate within the agreed budget and this means finding £11M of efficiencies.

**What are the savings you have to make?**
We have to make £5 million savings in community services across North and East Devon: £1.25 million in the North and £3.75 million in the East.

**Will these options actually save the money you need? What happens the next year and the next year?**
The NHS is required annually to make efficiency savings and this will continue for the foreseeable future. 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.

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 have no intention to take any savings out of the community teams.

**PWC looked at funding in health economy in Devon. This cost £1 million. The report was suppressed. We don't know what's happening with funding. Local MPs and healthcare organisations should get involved to get report published.**

**I've heard of trusts sending 6 people to Florida to a conference. Do you do this?**
No. There would have to be a very good justification to send someone to a conference overseas, and if we thought there was, we would just send one person and get them to feed back to the team.

**What is the cost of travelling time for community nurses?**
We have done extensive monitoring of visits and travel time and we know that it is more cost-effective to visit people in the community.

Community nursing staff have an option of using their own cars for work purposes and are then reimbursed for mileage in accordance with the NHS's national terms and conditions. This allowance reduces after 3500 miles. Alternative they can choose to be part of the lease car system or use a pool car.

The community nurses work in complex care teams which are based on town areas, each team covers a geographical area, so the nurses only travel in that area. A nurse from Ilfracombe would not be working in Holsworthy, for example. There are some overlaps, for example if there was a patient that needed to be seen on edge of the geographical area and that team was short staffed, we would ask someone from the neighbouring patch to cover.

**But you still have to look after those patients. You would just be moving people from Bideford to Barnstaple.**
A recent audit, carried out by said 30-40% of people who were in hospital on that day could be treated in a different way. We believe that these people can be better cared for at home. We know that 40% of people who are in a community hospital will end up being discharged to a care home. For people who are looked after in their own home, this number is considerably lower. People tell us they don't want to go into a care institution and we know we have to change the way our services are provided so we do more to support people remaining independent in their own homes.

**If the plan is to reduce the number of community hospital, won't the remaining beds become more expensive, making the hospitals less viable?**
If we were closing parts of units, with small numbers of beds, this would be true, but we have to keep minimum of 16 beds so we would not be running inefficient units.

Please remember, that we are not talking about closing hospitals. All the facilities will remain and we will develop health and wellbeing hubs offering outpatient clinics, gyms, pulmonary rehab, balance classes, blood transfusion, chemotherapy etc. We can use the space differently, such as leg ulcer club and other services to address social isolation, and will work with communities to find out what they need in their local area.

**Have you done any work to look at cost of increasing beds?**
The CCG's work looked at this and they came to conclusion that we needed less beds not more.

## Workforce

**Why are you considering putting beds into NDDH? You don't have enough staff there as it is.**
There is a national shortage of registered nurses. Last year the Trust spent £11million on agency staff to ensure we maintained safe staffing levels. If we could eliminate that level of spending, we wouldn't need to make the cuts we're having to now. The easiest places to recruit to are home-facing community services. Recruitment is difficult at NDDH, although it's improving. Community hospitals are the hardest to recruit to.

**Agency nurses are paid more than NHS nurses. NHS nurses leave to get an agency job, and I believe the agency itself gets £10 per hour. Why don't you pay them more, on a higher pay grade, to keep them within the NHS?**
Pay scales are set nationally and we can't change them. We are looking to work differently and with other Trusts to address the agency problem. Staff are offered the opportunity to work overtime, which can help to reduce agency usage.

**Offering overtime doesn't seem right. The nurses are already on their knees after a 12-hour shift.**
In most cases, the opportunities for overtime are for people who work part-time and may want to increase their hours.

**How can you reduce your reliance on agency staff?**
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.

**Will you need to recruit more community nurses to cover the extra work? Will these be private staff or NHS funded?**
We won't need to recruit more staff as we have enough nurses to transfer into the community. It is easier to recruit and retain community nurses than community hospital nurses. Any nurses we recruit will be NHS funded.

**Working in a community hospital is very different to working in people's homes. What is being done to train people to work in the community?**
We will work with the staff to look at their skills and competencies and agree with them where they would like to work, whether it is at another community hospital, in the community or at the acute hospital. We understand that working out in the community is different and may not suit everyone but we will give staff the help and support, through training and work-shadowing, to support them through this transition. In Ilfracombe, the nursing staff were redeployed into the community and they have been very happy with the move.

**If hospital beds are lost, what will happen to the cooks and cleaners?**
Elsewhere, some of these staff have moved into administrative or healthcare assistant roles or switched to another site where there are beds.

**If it is easier to recruit staff in the community, how come you struggle to recruit domiciliary care?**
The care you are talking about is longer term domiciliary care, which is commissioned by DCC and the CCG and provided by private companies. They are looking at how to improve recruitment in this sector.

## Other

**Do relatives get a say in when a patient comes home from hospital?**
Yes. Relatives are involved in the assessment, in conjunction with the multi-disciplinary team.

**There is talk of moving the excellent stroke rehab unit at Bideford to NDDH. This won't work.**
The stroke rehab beds at Bideford are not part of this consultation

**Are our MPs involved in any way in this process?**
We have regular briefings with MPs where we keep them up to date They are welcome to come to any of our meetings and input into the consulation.

**How does losing the Eastern services affect your budget?**
There is still a lot of work needs to happen following the Monitor decision, including a value for money assessment. If the Eastern services go to the RD&E, the community services budget in the North will not be affected.

**Have you done bed modelling? How have you come up with the number of beds needed, especially in winter?**
The CCG's consultation had a bed modelling paper which can be found here.
With reference to winter pressures, there is a northern locality system resilience group which includes the acute trusts, ambulance service, primary care, 111 etc. All organisations work together to have a plan for winter and we translate this into the plan for our trust.

**What is the exact number of beds?**
The CCG indicated that approximately 40 beds was appropriate, but it will have to be flexible. The number of beds would have to be in multiples of 8 and 16 would be a minimum, due to the fact that we cannot have one registered nurse working alone on a unit.

**Does this affect the minor injuries units?**
We have no plans to close the MIU. It is true that the CCG is running a review of urgent care that includes MIUs and Walk-in-Centres as well as out of hour GP cover, but the procurement exercise has been paused. While there is not an outcome, we will continue to run the service.

**What KPIs are you operating? Are there KPIs for measuring how effective the community services are?**
There are no national metrics for community services, but we monitor our own KPIs to ensure that our services are safe and high-quality. We monitor the people who are being looked after at home as well as emergency admissions to hospital, A&E attendances, length of stay in hospital and the number of people who get transferred to another community hospital.

We also look at performance and activity and quality, such as response times, waiting time for therapy, the length and complexity of visits. We publish all this information in the Trust Board reports

It is also important for us to measure patient experience. We look at whether people feel safe and well cared for. That is also published on our website.

Finally, the CQC inspections also measure how effective our community services are. The recent CQC inspection rated our community services very high, with the inspectors wishing they lived in Devon.

**If you are getting people out of hospital early, how often are people coming back in?**
This is another important measurement. Those figures are collected and published. It is not in our interests that people are readmitted, as we do not get paid for any readmission up to 28 days after discharge.