Bradford (Holsworthy) 4 September 2015

Questions and Concerns

Decision-making criteria

How are you going to deal with the surges in demand? You are condemning people to die on trolleys in A&E!
We flex beds up and down in our hospitals according to demand which means we meet the needs of our patients. We have escalation plans to cope with surges and this is one of the criteria we want feedback on - if flex is an important factor for you, and Holsworthy has capacity to flex at busy times, then please feed this back.

In North Devon we are very proud of our winter planning. Unlike some other hospitals in the area, we haven't gone into black in the last three years and our red alerts have significantly reduced. However, there are times when the system is under great pressure. When this happens, we get a pre-warning at red alert so we boost community services to prevent people going into hospital where we can and to support people so that they can come out of hospital as soon as possible.

We have heard little about the ageing population; surely you should not be removing beds when we have more frail elderly people in our society?
There will always be beds for people who need them, but we believe that for the majority of elderly people, being looked after at home is much more beneficial. We know that if someone stays in hospital for over 11 days the chance of them getting a complication simply due to the fact that they are in hospital is high. We believe that, where clinically appropriate, the safest place for people is in their own home.

Home-based care

What happens if you fall in your own home and your carer is not coming in until the next day?
We would hope that if you are in danger of falling, you would have an alarm which you could use to call someone. Please do be aware, though, that the risk of falling increases if the patient is not in their own environment.

Who does the assessment to determine if the patient is able to be looked after at home?
There is a multi-disciplinary team assessing for discharge. This will include medical, nursing, therapy and social care input. Someone will not be discharged if it is not safe to do so and the appropriate package of care is in place.

What do you mean by care at home?
It is difficult to describe this generically as it is very personalised to the patients' needs. However, in this consultation we are talking about the short-term health-

funded care that replaces a stay in a community hospital. Our complex care teams consist of community nurses, therapists and social workers who are supported by a coordinator. The team knows when a patient from their caseload is admitted into a hospital and they will work with the wards to make sure that the right level of care is in place for when they come out. Please be assured that we would only treat patients at home if it is safe to do so.

But what care we will get on a day to day basis?
It depends on the needs of the patient. It could be a nurse to come and replace dressings, and a physiotherapist to come in and do some exercises on a daily basis. If necessary, we can offer night-sitting which means that people can have 24 hour care for a short period of time. Please be aware that we are not consulting on the domiciliary care that is already in place, we are talking about the health-funded care that will increase as a result of moving services from hospital to the community.

Can you explain why there is an increased risk of medication error in hospital rather than at home?
The percentage of medication errors reported by staff is slightly higher in hospital but medication incidents can also happen at home. Medication errors happen in hospitals for a number of reasons including inadequate written communication, problems with medicines supply and interruptions/distractions during medicines administration rounds.

How do you ensure that you get services to people in bad weather?
We regularly visit people in very rural areas. Each winter we face challenges but our community teams and the care agencies we work with have very robust contingency planning for bad weather. Our community teams are very used to getting out to visit people in difficult conditions. When the weather is really bad we use our knowledge about where staff live to ensure no patient is missed.

When we know bad weather is coming we make a plan with each patient, their family and carers, for how we will deal with these situations. These plans are shared with our partners so that we all know what we will do in an emergency. We have never missed a patient in these circumstances.

Consultation process

When does the consultation end?
The consultation ends on the 29th September and the Board meeting will be on 6th October, where a decision will be made.

Is there time to ramp up the services to cope with the reduction in beds before the winter?
Yes, we believe we can get everything in place before the busy winter period hits, but we need to move quickly to achieve this.

Why has the CCG paused its consultation? How will this work?
We are charged with delivering safe and effective care within the budget given to us each year by the Clinical Commissioning Group (NEW Devon CCG). The Trust's consultation process is constrained by the budget for a financial year ending in March 2016.

The CCG has confirmed it supports our right to consult on delivering services within the budget we were given this year.

The CCG is charged with the long-term strategy for local health services and is proceeding at a different pace. The CCG feels it is clearer for stakeholders and the public if we separate our two processes, and we respect this point of view and decision. We are ensuring that our options are aligned to the objectives of the CCG's Care Closer to Home strategy and nothing we do will prejudice any future decision that the CCG makes.

The finances

You said that when you closed the beds you invested the money into home-based services. So how do you make a saving?
We are planning to make a net saving of approx. £700K per 16 bedded unit if we invest £10K into community services per bed replaced. These are planning values and such may vary according to the community services that are implemented

How is it more cost effective to deliver services in the community?
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.

Also, we are already looking after 7000 people in their own homes, so we are already set up to do this. The number of people from community hospitals, who would now be cared for in their own homes is a very small number compared to this.

However, it is not all about the money. We all know someone who has been treated in hospital and treated well, but 40% of people who go into community hospitals never go home and end up being discharged into a care home. We truly believe that this is a better model of care through being treated at home, people can maintain their independence. We would like to assure you that safety is our paramount concern and we will not just go for the cheapest option.

It is not our job to worry about your money problems - if we got rid of all the managers we could save the money.
We are not asking you to worry about our money problems, but are consulting on how we can deliver safe and effective care within the budget, so the finances do play an important part in this. If you have other suggestions on how we do this, please feed them back as part of the consultation.

Workforce

You have loads of Italian and Spanish nurses 100 of each at least at RDE alone!
We can't comment on the RD&E's staffing situation, but we do have a large number of nursing vacancies and do go abroad to try and fill those vacancies.

We do have a problem recruiting staff into our community hospitals and the use of agency staff is a significant problem for us. We spent £11m on agency staff last year which is unaffordable and does not offer the same continuity of care on our wards when we become over-reliant on agency staff. We are bringing down this spend by improving our recruitment, promoting return to work packages and ensuring that we support and develop our staff so they want to stay working for us. We are also working with Petroc to develop innovative apprenticeship schemes that encourage young people from the area to work in healthcare and gives them a career progression.

Other

What happens if someone has a stroke? Patients need access to hospital within one hour; can clot busters be given in transit?
When people have an acute stroke in Devon, they need to be taken to NDDH as soon as possible. This is a medical emergency and the drugs cannot be delivered in the community.

How when we have given a £1bn to Syria we can't provide the proper care for people in our own country?
I'm afraid we don't have an influence on how much money is spent on international aid!

We don't need acute hospitals we do need more community hospitals.
We believe that there has to be the right mix between acute hospital beds, community hospital beds and community services. We and the CCG have done a great deal of work to determine the best configuration of these services. The CCG has come to the conclusion, through extensive modelling, that approx. 40 beds is appropriate for community hospitals.

You state that most of these patients are step down - they are not.
Our community services offer both step down and step up care. Step down care helps people to get home from a stay in hospital sooner. It focusses primarily on rehabilitation. Step up care helps people to avoid an admission to hospital, and largely involves the Rapid Response service. These services form part of the home-based care service and will be enhanced in areas where beds are removed.

In Northern Devon, approx 85% of patients receive step down care (taking up 90% of capacity as these patients generally stay longer) and 15% (10% of capacity) receive step up care.

What about people who end up in a dementia home who don't have dementia? This ends up in your medical records and affects your care going forward.
Having dementia on your medical records is only related to a diagnosis of dementia. Where you are placed has no relation to what appears on your medical records.

Why have you not done this before if it is better?
Things are always evolving in the NHS, and as technologies, processes and working practices change, services can be developed. In the past, when someone had a hip replacement, they would be in hospital for a couple of weeks. Nowadays, we can get them out of hospital and into rehabilitation after a couple of days. It takes time for people to accept these changes and for the systems to be put in place, but we are constantly looking at better ways to care for our patients.